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THE QUESTION OF HONESTY

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At the 21st Annual Meeting of the Saint Elizabeths Medical Society in 1958 I presented my experience with a patient who developed cancer and died in the course of psychotherapy. The case itself was interesting and unusual, but in the course of treatment the question of honesty with myself and with my patient turned out to play a crucial role. The way I worked with her had so clearly emerged from the overall situation that I had taken it for granted. I was quite astounded when it was the question of honesty which became the matter of most interest to those who heard the paper. I then became curious about the extent to which honesty might be discussed in psychiatric and psychoanalytic literature. I was again surprised to find that references both to honesty and truth were remarkably absent. The words literally never appeared in indices and seldom were mentioned as such in the text! They were somehow implied and vaguely assumed. Neither occupied a prominent place as an entity for deliberation in and of itself, although the search for Truth has long been an axiom of science. And, in its higher aspirations, our field professes allegiance to the scientific method. Students are advised to be kind, warm, reassuring, tactful, and considerate; but they are not specifically advised to be honest. Recent emphasis on countertransference in the literature has brought greater interest in honesty,

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but, although there is general agreement that the therapist should be honest with himself, there is wide disagreement on the extent to which he should honestly share his feelings with his patient.[1] One becomes aware that there is a fine line between an honest admission and a self-flagellating confession. Most of my readers are familiar with the teachings of Sullivan[2] and Fromm-Reichmann,[3] for example, in regard to telling the patient what we already know about him at the beginning of the initial interview, and admitting quietly and honestly when we have made a mistake.

This paper presents some observations from professional literature, from clinical practice, and from my own general experiences in living, which I hope will stimulate further discussion and which may demonstrate difficulties in ascertaining the truth in conflictual situations and in sharing that truth with our patients. My observations are intentionally broad, not restricted to psychiatry alone. I think they are relevant for all of us whose work brings us in intimate contact with others. (If one were to substitute pastoral counselor or minister for psychiatrist, and parishioner for patient, the observations are equally valid.)

We accept that truth and honesty do not exist as absolutes, and we do not presume to advocate specific rules for honest behavior that can be pronounced as technical or ethical dogma. But we are concerned and puzzled at the relative absence of these concepts in an area of human relationships which depend so much upon their successful application.

A confusing continuum between the unconscious and the conscious leads to difficulty in clarifying the application of our terms to human behavior, since honesty by definition seems to imply conscious intent. According to Webster, honesty is defined as "freedom from fraud, absence of intent to deceive, and implying candor, fairness, straightforwardness." Truth is stated to be "in general, conformity to fact or reality." Other definitions offer such unhelpful concepts as that truth is the quality of being truthful, and honesty the quality of being honest. Robert Oppenheimer recently said cryptically, "Truth is so largely defined by how you find it."[4]

Nonetheless, each of us has a general notion of what we mean. In my own work I see honesty as an attempt to establish what appear to me as facts, in accord with reality as I see it, notwithstanding its contradictions and confusions, and to communicate this information to the patient according to what, in my judgment, is within the limits of his capacity to understand and to integrate it. To attain honesty in this sense is not easy. The situation is complicated by the question of honesty when, to whom, and

[1]Orr, Douglas R.: "Transference and Countertransference, a Historical Survey," *Journal of the American Psychoanalytical Association,* II (1954), 621-671.
[2]Sullivan, H. S.: *The Psychiatric Interview;* Norton, New York, 1954.
[3]Fromm-Reichmann, F.: *Principles of Intensive Psychotherapy,* University of Chicago Press, 1950.
[4]The Great Challenge, CBS Television, Robert Oppenheimer, *et al.*

about what. In the practice of psychiatry it is unclear much of the time what mode of behavior with each patient is most likely to bring about a state of trust and mutuality upon which, by general consensus, a successful therapeutic relationship must ultimately depend. One may ask, what is the role played by honesty in bringing about this trust? One's basic and personal integrity must be the keystone to the solution.

I recognize that I have introduced a number of terms which might be further defined, but I would prefer that each therapist provide his own connotation of trust, mutuality, integrity.

The question of honesty separates itself into two vaguely differentiated areas, with elements of conscious and unconscious selectivity in each. The one has to do with the psychiatrist's thoughts, feelings, motivations, with his state of awareness of these, and with their communication to the patient. In our training, this is largely dealt with by therapist, training analyst, and supervisor. The other has to do with the recognition and selection of relevant data about the patient or about others significant to him, and again with their communication to the patient. This is dealt with mainly through our clinical and other experience and by our theoretical training. Of great importance to both are our personal value systems and our experiences in living. In each case judgment is involved, though the kind of judgment will vary; but in no sense should honesty be so relative as to be meaningless.

Although the criteria of honesty will change considerably in detail and application according to our particular profession and orientation, the basic problems are the same for us all. While the psychoanalyst should have the advantage of greater self-awareness, he is, nonetheless, faced with the same kinds of decisions and subjected to the same kinds of pressures as are others. And, in many instances, there is an additional pressure by virtue of self-awareness itself. Honesty always involves decisions. We cannot escape the real and recurring possibility in human relationships as elsewhere of honestly drawing opposite conclusions from the same set of data. I shall illustrate some of the many different kinds of situations in which the question of honesty arises.

The dilemma is framed by two quotations: The first is from Freud in 1938—his last summary statement:

> But we never fail in all this to make a severe distinction between *our* knowledge and *his* knowledge. We avoid telling him at once things that we have often discovered quite early, or we avoid telling him the whole of what we think we have discovered. We consider carefully the moment at which we shall impart the knowledge of our constructions to him; we wait for what seems to be a suitable occasion—a judgment which is not always easy to make.[5]

The second quotation is from Wertenbaker, later aware of his own fatal cancer, in 1957:

[5]Freud, Sigmund: *An Outline of Psychoanalysis;* Norton, New York, 1949, p. 71.

> A few days earlier, I had a long discussion with my wife about one aspect of the situation that troubled me: the reluctance of many doctors to tell a patient an unpleasant truth. Ever since I can remember, it had seemed to me that to be deceived about the nature or progress of serious illness, or even to suspect deceit, would go far toward destroying whatever fortitude one could summon to face one's trials. My wife had agreed with me immediately. "To tell you anything less than the whole truth would be to reduce you," she said. "I promise you I will never do that." Neither of us then suspected how much pressure she would have to resist to keep that promise.[6]

It is not clear to what extent Freud is speaking of facts or of opinion. Can we judgmentally evaluate the intent of the "deception" about which Wertenbaker speaks?

One of my patients said, not too long ago, "As long as the possibility exists that some doctors do not always tell their patients the whole truth, for whatever reason, then I can never fully believe any of them." Freud was bitterly angry when he learned that the truth of his cancer had been initially withheld from him by his medical colleagues and friends, even though their decision was made on the basis of their honest conviction as to what was best for him. He later softened his views toward them and apparently toward such a policy.[7]

A few years ago I was called by a medical colleague to assist him in handling a grossly disturbed patient in her home. I arrived to hear her loud, hysterical screaming, and to find the doctor surreptitiously preparing a syringe with which to render her unconscious for transportation, without her knowledge, to a state hospital 150 miles away. To him there was no alternative. I persuaded him to let me talk to the patient, explaining that I was not sure such drastic action was necessary. When confronted quietly but unyieldingly with the fact of her obvious need for help and the preference for her cooperation and voluntary participation, she agreed to be admitted to a local psychiatric ward and quietly made the necessary arrangements, packing her bag, planning the interim care of her child, and walking to a car parked out front. It had not taken great skill to convert a frightening crisis into a meaningful collaboration. Had he been less anxious and more honest, my colleague could have averted what to me was a near catastrophe.

That honesty about science in general is a matter of concern to the professional and the public alike is exemplified by the following selected references:

Writing recently in the *Saturday Evening Post* about basic research, Hans Selye said, "It may seem redundant to say that the newly discovered facts must be true, but by this I mean they must be both correct and seen in

[6]Wertenbaker, Lael: *Death of a Man;* Random House, New York, 1957, p. 5.
[7]Jones, Ernest: *The Life and Work of Sigmund Freud,* Vol. III; Basic Books, New York, 1957, p. 93.

proper perspective. Otherwise the finding may be misleading because of the inferences drawn from it. . . Few scientists knowingly publish untruths, but many scientific papers contain such untruths by implication."[8]

William Beck, again in a non-professional magazine, the *Saturday Review of Literature,* writes, "The idea of dishonesty in science is a hard one to swallow, for it is as difficult to understand as it is shocking. . . What dishonesty exists among scientists is subtle and, no doubt frequently unconscious behavior." He further reminds us that the competitive race for priority leads to doubletalk and breeds dishonest reporting.[9]

Kubie, writing in the *Psychoanalytic Quarterly* about the process of supervision, points out that ". . . the student has simultaneously to be a free reactor, a participant in a complex emotional exchange, an observer, a recorder, and an objective recounter of this whole intricate chain of events . . . it has long seemed that any true resemblance between the student's report and that which had actually taken place is almost a miraculous accident."[10]

Felix Deutsch, in his recent book on the clinical interview, reminds us that "an intelligent student soon learns to report material in a manner and of a nature approved by the teacher."[11]

Subjected constantly to pressures of one kind or another, even the most mature person yields to conscious and unconscious distortions.

To deny that dishonesty ever threatens our work is to deceive ourselves. At best we cannot avoid it. To the extent that thoughts and feelings are unconscious or denied they can cause difficulty. Maneuvers and techniques honestly intended to produce desirable results are part of our legitimate professional skill. We make no secret of them. They are designed to establish trust and to elicit information—both of which will help the patient. But the very act of denying to ourselves the possibility of our dishonesty in these techniques may lead to self-deception and overt dishonesty. The discussion becomes circular when one again questions the role of honesty in establishing trust. It is too easy for the doctor to use his culturally assigned role of beneficent benefactor to build up trust and confidence through misleading, and essentially untrue, reassurances. How honesty is handled by both doctor and patient is a factor growing out of the experiences of each with significant people in their early lives and depends on the extent to which they developed trust or later resolved their tendency to distrust. Since complete honesty is never possible in child-rearing or in

[8]Selye, Hans, "What Makes Basic Research Basic?" *Saturday Evening Post,* Jan. 24, 1959.
[9]Beck, William S., "Science and Dishonesty," *Saturday Review of Literature,* Aug. 2, 1958, pp. 36-37.
[10]Kubie, Lawrence, "Research into the Problem of Supervision in Psychoanalysis," *Psychoanalytic Quarterly,* XXVII (1958), 226-237.
[11]Deutsch, Felix, and Murphy, W. F.: *The Clinical Interview;* International Universities Press, New York, 1955.

later life-experiences—including treatment—we all must have some residual of distrust with which we must cope. And, since nature is capricious, complete trust would be unreasonable as well as impossible.

"There's nothing wrong with you but nerves!" "You'll feel better tomorrow." "I can cure you in six months if you just do what I say." These are familiar words in many settings. In our enlightened days one still hears that people are afraid of psychiatry and that they don't want to hear the truth. Maybe so, but there are a remarkably large number of people who are willing to eschew the tranquilizers and to spend their time and hard-earned money talking to someone who offers no guarantees, promises no cures, and cannot tell how long it will take to do what.

An interesting example of the way in which one selects different things to be honest about with different people, and of the problem of where the truth really lies, came with a case of an ambulatory schizophrenic woman and her husband. The patient was aware that her thoughts were bizarre and was frightened and depressed by them. She felt, rightly, that her husband did not understand. He was unable to admit that her troublesome behavior was part of an illness and was both angry at her and resistive to the idea of prolonged treatment. Concerned about the patient's paranoid symptoms, I attempted to minimize my contact with the husband by referring him elsewhere for guidance and, if possible, for treatment for himself. When he did not go, I saw him myself—to my patient's great relief. She wanted her husband and me to work together, and my job, successfully carried out, was to convince *him* that she was sicker than he thought and that she might not recover, and to convince *her* that she was less ill than she thought and that she could get well. My efforts brought each of them to a more realistic appraisal and to a harmony that had been missing for years. In all situations where the same therapist sees more than one member of a family the matter of trust is one of great concern. One must maintain confidentiality while at the same time making effective and honest use of important information that each may give about the other.

All of us at one time or another have had the experience of leaving our patients for various reasons—vacations, conferences, illnesses, or transferring our practice, to name a few. We often try to explain or justify these separations to our patients as something other than what they are—the result of a decision, no matter how realistically important, that something or someone else is more meaningful to us than they. Working through this separation can be a vital part of the patient's curative process, the success of which depends largely upon our ability to handle, openly or otherwise, our own ambivalence over the separation. There is, too, the problem of when to tell any given patient and how best to present it. Often we know for weeks or months prior to the action that we will be taking it, although the amount of certainty and the number of known details will vary. To what extent is our relationship to the patient affected by our knowledge when such knowledge has been withheld? When we

work in an institutional setting where rumors are rampant and where our patients may know each other, *how* do we deal honestly with these matters? It reminds us of finding the optimal time to tell a child of an impending operation.

One cannot underestimate the effects of withholding knowledge on the person doing the withholding. The patient may know or sense what is going on, or the psychiatrist may wonder what the patient may know or suspect. Depending on our awareness of this and our comfort about it, we may experience conscious or unconscious guilt. That the psychiatrist is sometimes aware of trouble in himself in this area suggests that there are probably other times when he is not so aware. The patient then may react either to the psychiatrist's anxiety or to the suspicion that something is being withheld from him. *How* one deals with these complex feelings is a subject for a discussion of countertransference, but it does concern honesty.

However, we can use a meticulous kind of honesty as a hostile or guilt-motivated way of overburdening the patient with our own unresolved problems. Since we do not yet know either our patient's strength or the extent to which the strength borrowed from the psychiatrist can help him in facing painful confrontation, we are generally advised to be cautious in early interviews. On the other hand, bold and honest confrontation can sometimes be both useful and necessary even in a first interview in order that the patient might trust the therapist enough to continue. As the patient improves, we may become less protective, more spontaneous, and more casually honest. This is due in part to the fact that our first impression cannot always be trusted, and that what later emerges as a fact is initially only an unconfirmed impression. We do not always try to work through our strong initial negative reactions to new patients, and not infrequently we refer them on for reasons which are either overt or covert disguises. It troubles me to see the rather hostilely condescending attitude under the guise of "kind understanding" that colors advice on interviewing techniques given to students in most textbooks in all our associated disciplines—*including psychoanalysis,* whose writers should certainly know better. A person already sensitized to hypocrisy will see through ours, or will at least respond negatively to it, and will report it to the next psychiatrist. Although dishonest attitudes often temporarily or permanently discourage the patient from further efforts, should we tell the young man that he reminds us of our cousin Willy who, despite seventeen years of our own analysis, still remains an obnoxious pest; or do we beg off on a full schedule, full at least until someone more interesting comes along; or should we simply tell the patient that we do not think we can work with him and let *him* figure out why?

It has been said that "hypocrisy is the compliment that vice pays to

virtue."[12] Tact can be described as a selectively judicious use of the truth tempered with kindness and coupled with an honest attempt to gauge the other person's capacity to accept and to integrate whatever painful thing it is he must be told.

Working with an extremely sick person as an outpatient can present insurmountable obstacles. Without the assurance of a supportive and protective environment, the anxiety of the patient, the psychiatrist, or both, may make impossible honest confrontations which, with the aid of a hospital or its staff, can be made. Although one is continually encouraged by people's ability to face pain, one hesitates to go with a patient to the edge of despair and to face it with him boldly when one has no certain means of knowing what will follow when the patient leaves the office.

The following case demonstrates the kind of dilemma in which one occasionally finds himself. A middle-aged woman was agitated, depressed, and passive to the point of annoying helplessness. She repeatedly forced her husband into conciliatory behavior which both protected her and further lowered her already low self-esteem. The pattern, however, was so well established that it was difficult to tell how much his response was a destructive overprotectiveness and how much it was by now a necessity for her survival. She was driven by car to her appointments by her husband, and one day, early in treatment, he had left her and we had shortly begun. The telephone rang, and, answering it in my office with the patient a few feet away, I heard him, without preface, ask me not to tell his wife that her mother had been seriously hurt in an automobile accident three days previously in a neighboring state. I was angry at being placed in such a position. I was in agreement with his doubts about how well she could handle this news. She had always been protected and might not tolerate a sudden shift in this approach, but, because of the way he had handled things so far, I felt that he and I had some things to talk over before he discussed this with her. He said he would get further information and talk to me later. When I called him later in the day I was surprised to learn he had given his wife the news immediately upon leaving my office and that she had apparently taken it well. When I saw her again we discussed what had happened. A few days later she attempted suicide.

An example from my extra-therapeutic experience points up still another aspect of the dilemma. An acquaintance recently developed cancer and was dying. Her husband was adamant that she should not be told the diagnosis, but at the same time requested that many people see her at the hospital before she died. I wanted to see her but had no opportunity to talk the situation through with him before I went. By the time I arrived, it was becoming obvious to the patient that the illness was not progressing favorably. Though she hinted, she lacked the courage to ask directly for the truth, preferring, apparently, that someone else be strong. Uncom-

[12]Schmideberg, Melitta, "Hypocrisy, Detachment and Adaptation," *Psychoanalytic Review,* XL (1957), 401-409.

fortable with the plan, I found my visit a difficult one. I was divided in my loyalty and did not feel free to follow my own inclinations. It seemed unfortunate that the patient was forbidden the opportunity to face the truth if she wanted to. Was I honest to the patient in going along with the deception? Would I have been honest with her husband if I had not? And, under the circumstances, how could I be honest to myself? Unless what appear to be facts are shared with us we are left with only fantasies. And such fantasies give us neither a real cause to fight nor a solid foundation for hope.

The problem of truth and trust is stated clearly in this verbatim quotation from a randomly selected daytime radio serial[13]—an unlikely place for psychoanalytic truths:

THE GIRL: There are some things you'll just have to trust me with until we know each other better.

THE BOY: How are we ever going to get to know each other unless we start with the truth?

THE GIRL: When you're ready to believe in me completely, then I'll tell you the truth.

This merely states the problem. It does not answer it. Erikson states it in a more sophisticated way, but still only approaches an answer. Truth he defines as "the assured reliance on another's integrity." "Mothers," he says, "I think, create a sense of trust in their children by that kind of administration which in its quality combines sensitive care of the baby's needs and a firm sense of personal trustworthiness within the trusted framework of their culture's life style." And, "Parents not only have certain ways of guiding by prohibition and permission; they must also be able to represent to the child a deep, almost somatic conviction that there is meaning to what they are doing."[14] It is not difficult and is, I believe, valid to extend these concepts to the therapeutic relationship.

In order to find the means of bringing a relative state of trust into a relatively enduring therapeutic relationship, we must constantly study the nature of the therapeutic processes that bring about both successes and failures in treatment. It seems to me that we too often underestimate our patient's capacity to deal with the truth about a given situation as we may see it. In shielding the patient from the truth, we perhaps overestimate our importance to him and underestimate his capacity to decide upon the validity of our observations for himself.

I believe that it is vitally important for us to try to be honest in our lives—professional and otherwise. I am sure that we will often fail, and I am sure that part of the failure stems from the very relativity of truth. Lacking omniscience, the psychiatrist cannot always know what is best for himself or for others. But a part of the failure is the failure to

[13]Don Ameche Complete Life Story, NBC Radio Network, 10:30-11:00 a.m., June 25, 1958.

[14]Erikson, E. H.: *Childhood and Society,* Norton, New York, 1950, pp. 221, 233.

try. The thoughts expressed in this paper I have intended only as an exploratory stimulus and the means of rekindling an awareness of an often-overlooked aspect of therapy.

Discussion of Dr. Young's Paper

I was glad to have the opportunity to read Dr. Young's interesting and provocative paper and to gather thought together for a discussion of it.

While it is true that honesty or truth as such is rarely mentioned in psychiatric or psychoanalytic literature, Freud refers to it constantly. We should recognize that it is the initial premise and the essential part of the contract that the patient makes in establishing a therapeutic arrangement. Freud said:

> . . . the psychoanalytic treatment is founded on truthfulness. A great part of its educative effect and its ethical value lies in this very fact . . . Since we demand strict truthfulness from our patients, we jeopardize our whole authority if we let ourselves be caught by them in a departure from the truth.

The problem that needs to be raised, as Dr. Young has done, has to do with the therapist's part of this bargain. This is not a matter of counter-transference, but a prime essential in the whole problem of the physician's —and, in a larger sense, any helper's—responsibility to his charge. This is the area in which the question demands extensive discussion.

First, we must not confuse our concepts. In this field semantics must occupy an important place. Honesty is not the same as truth, although the two are related in curious ways. I won't quibble with either Dr. Young's or Webster's definitions. But I would like to draw attention to the possibility that honesty is a dynamic concept based on an individual's sincere and unbiased attempts to appraise a total situation, limited by his essential inability to be totally unbiased. Truth is a matter of definition according to the framework in which it is established, whether scientifically, as in nature, or morally, as determined by man or God. This explains Oppenheimer's definition: "Truth is so largely defined by how you find it." He means simply that what is true depends upon how you set out to determine the truth.

This distinction is crucial in a discussion of truth, honesty, or trust and faith in the therapeutic process, since it can help to avoid many of the dilemmas that Dr. Young has posed.

For example, we must recognize that honesty is not exclusively a moral question, since it is determined by the degree of freedom the individual has to explore, express, and determine the truths in his environment. It is strongly influenced by the amount of neurotic defenses the individual has and the degree of distortion he must impose on the environment by denial, projection, dissociation, and so on. Here the degree of honesty is determined by the security and self-esteem of the individual which allows him to be more or less honest in seeing a situation as it really exists. Dishonesty is a

defensive maneuver, whether consciously elaborated or unconsciously propagated, designed to support a neurotic system. We distinguish the deliberate from the unconscious liar only because we still tend to assign moral judgments to those degrees of distortion. Is the child lying when he tells you about the fire engine drawn by elephants and led by a Maharajah, a la Dr. Seuss, or is he simply using his imagination? Are our patients being dishonest when they tell us that they are not irritated when we cut short their hours because they are afraid we will get angry and terminate therapy? Are they being dishonest when they completely falsify an ancient experience of childhood because they remember it as their having been bitten by the dog rather than as their having kicked and hurt the dog? This exemplifies some of the vagaries of the notion of honesty which cannot simply be appraised but must be understood in the context of the experience. Honesty is a human potentiality, achieved only where there is a minimal need to defend oneself against anxiety because of a sufficient self-regard which enables one to see a situation for what it is. Whether we communicate this honest appraisal into a statement of truth or withhold it for reasons that may be justified, our goal in the training of therapists should certainly be directed toward encouraging and developing this basic honesty in our human contacts. Dishonesty is the inevitable consequence of the neurotic structure and occurs when our defenses demand some distortion of reality, whether by total reversal, slight distortion, exaggerating, minimizing, shading, and so on. This tendency in the neurosis is generally not subsumed under the category of dishonesty, but rather is considered a problem of defense. This is made possible by refraining from moralizing judgments and recognizing that these distortions of reality are a necessary and essential activity in the neurotic state. It is this element that has led many theorists, particularly Horney and Sullivan, to consider neuroses as immoral and in the category of ethical diseases. Certainly the neurotic is dishonest, but, since he is unable to make any choices, his dishonesty is imposed upon him by his neurotic structure. He does not wish it, would like to be rid of it, would like to rid himself of his dishonesty. But in therapy we prefer to talk about defenses rather than honesty, since the problem of honesty is so loaded with moral, theological, and ethical judgments.

Now this notion of honesty brings us to an examination of the concept of truth. Dr. Young has given us many interesting definitions of truth. These are all true, yet none of them is entirely true. And this is precisely the limitation of truth unless we believe in an absolute truth. To say that something is absolutely true is immediately to tell a lie, for truth is entirely dependent on our frame of reference, as Einstein has plainly demonstrated in his experiments in relativity. Yet I must agree with Dr. Young that, if we establish a sloppy relationship about truth, we have chaos. Consequently, humanistic societies and civilized man have agreed on some basic truths which we call morality, and proceed from these.

Now let us return to the questions raised in Dr. Young's paper.

Honesty in the therapeutic process, as I said before, is an absolute essential for patient and therapist. It is unthinkable that a rational, humanistic, non-authoritative healing process can proceed without it. I agree with Dr. Young that it is too often demanded of the patient and not often enough required of the therapist. Many therapies, such as magic, proceed in an atmosphere which could be defined as dishonest, but these are not subsumed under the strict category of psychotherapy by mutual exchange, as defined by Freud. What needs to be clarified is not whether, when, to whom, or about what one should be honest, but how to use our honest evaluations, appraisals, and judgments in an effective way. This is a question of technique, or at least it should be exclusively so. While we should not deviate if we can possibly avoid it from an honest involvement in our therapeutic work, we must constantly make decisions involving how best to utilize these appraisals. The question is not when to be honest, but when to communicate our honest findings so that they most effectively serve the therapeutic process. This is not a matter of truth, but more often a matter of judgment in the technical process of therapy. When do we inform an incipient schizophrenic of a panic-inspired dream?—not should we inform him or should we not? When do we inform a patient that we dislike this or that behavior and find it obnoxious?—not should we or should we not? These questions are all in the nature of technical issues. The question of the therapist's honesty in appraising this situation must be assumed and required without question. What we communicate is a different question from whether we honestly appraise the total situation. We must not mix up honesty with technique, for without a basic honesty the question of therapy itself is in jeopardy, and the technical problem never arises. Unfortunately for many therapists, this decision never arises, since they automatically decide to withhold unpleasant or distressful observations, interpretations, or communications because of their own inability to handle the consequences of their message. Here, however, we are not dealing with honesty or truth, but with either an incompetent or an immature therapist, who has greater concern for his own welfare than for that of his patient. At times, though, it may be the overwhelming characterological problems of the patient that put the therapist on the defensive, and one must acknowledge that it could happen to any therapist, however skillful, experienced, or mature.

On the matter of truth I think we can be much clearer. I cannot visualize many situations in which an untruth can be justified in the healing profession. Certainly we can deal endlessly with the cancer dilemma, but, putting it aside for the moment, I think we would all agree that in the psychotherapeutic process an untruth is *never* justified. This must also be clearly distinguished from withholding the truth for definable reasons. Our rationalizations may be incorrect, our justifications fallacious, but withholding is quite different from telling a patient a lie. Freud made this clear in my opening quotation. It is too easy to justify our withholding the truth for reasons ostensibly beneficial to the patient, when we are really

protecting ourselves. It is too easy to blame failures in therapy on our patients when our own skills are at fault, etc. But this is a matter of recognizing our own deficiencies, and, as Dr. Young has pointed out, our patients are better able to handle unpleasant material than we ever give them credit for being. Yet here again we must not confuse technique with truth. Certainly in the present state of development of psychological theory our interpretations and observations are a long way from being verifiable, and consequently we may not be withholding a truth if we refrain from making an interpretation, but rather withholding an opinion. We can establish some honesty in our appraisal only if we allow ourselves the freedom to examine human experiencing from an unbiased, unpreconceived, unreified set of concepts. The truth of our observations lies somewhere far in the future. At present we deal only with skilled guesses, approximations, and rudimentary scientific observations. We must never fool ourselves about the phenomenon we are observing, even if we frequently present it to our patients as the truth. And this raises a question Dr. Young did not touch upon, but one which also merits serious consideration: what we do present to our patients as truths although they are merely educated approximations. Such misrepresentation is as harmful as lying or withholding, and perhaps even more so, since it is much more frequently resorted to. Here we use our privileged status to establish a set of "truths" in our patients which are often far removed from any definition of truth.

Perhaps in raising these additional issues I have complicated the situation which Dr. Young described. My purpose was to distinguish between honesty, truth, and the wisdom of certain technical interventions in the therapeutic process. While there is no virtue in an absolute doctrine of truthfulness in the therapeutic process, there seems never to be a justification for deception. But, as I have said that honesty is relative to the state of security of the individual, so we must recognize that the therapist is also human, involved in neurotic difficulties, defending himself with denials, etc. However, we hope that he has less need for such defenses than has the patient, and consequently that we have a right to expect less deception on his part.

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METAPHYSICS, RELIGION, AND PSYCHOTHERAPY

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In the physical sciences, the swing from a thesis of prescientific speculation to the antithesis of a cocksure empiricism has been followed by a wholesome heuristic humility in search of a synthesis. The resurgence of an attitude that is willing to acknowledge aspects of reality beyond the reach of science has been recognized both by its opponents and its advocates.

Hook (19), in describing this trend, comments: "In the schools, the churches, and in the literary arts the tom-tom of theology and the bagpipes of transcendental metaphysics are growing more insistent and shrill." He contends that "the refurbishing of theological and metaphysical dogmas about the infinite as necessary presuppositions of knowledge about the finite" indicates a latter-day "failure of nerve."

Flewelling (13), on the other hand, declares that "the traditional abrogation of metaphysics by science has been brought to sudden pause." Citing the philosophical implications of relativity, indeterminacy and the new significance of the observer in physical phenomena, he concludes, "The positivistic philosophies, in faithful obedience to the dogmas of a discarded science, still 'hold the sack' waiting for the materialistic rabbit, while contemporary science approaches a new personalism."

Metaphysics and the Science of Man

The sciences of man have been slow in reflecting this change. The pendulum has swung from psychology's early identification with metaphysical philosophy to an extreme empiricism. As Borow (7) has expressed it, "When psychology joined the company of the experimental sciences, it embraced empiricism with a vengeance." There is increasing conviction that an ultimate synthesis will require recovery of some of the elements that were rejected by psychology in the process of achieving recognition as a science.

Psychology becomes most deeply involved in metaphysical issues when it turns to the treatment of personality ills. Contemporary psychotherapy is

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confronted by a question that has far-reaching theoretical and practical implications: "What is to be the place of metaphysics in psychotherapy? At opposite poles are those who are trying to "exorcise the metaphysical gremlin" (7), and those who hold that "at the bottom of every neurosis there is a metaphysical problem" (2).

Some of psychology's reluctance to modify an empiricistic rigidity is traceable to the influence of Freud. In his lecture, "A Philosophy of Life," Freud (15, p. 203) asserts the adequacy of science to achieve a full understanding of personality. While acknowledging that the world view of science is incomplete, he disdains and disparages the constructs of philosophy that would offer a more complete tentative picture of the universe. He denies any validity to philosophy and religion, and stakes out "the whole field of human activity" as the exclusive province of science.

Much of the psychotherapy now being taught and practiced has its roots in the Freudian system. Freud's personal philosophy has often been tacitly regarded as a part of psychoanalysis, although there is evidence that he himself acknowledged the separability of the two (26). Because they are frequently interwoven, Freud's reductive naturalism and the principles of psychoanalysis have had widespread influence upon American psychology and psychiatry.

Some of the present-day protests against this influence are voiced by Stern (41) and Maritain (22), who see Freud's reductionism currently producing a devaluation of man, contempt for the spirit and a loss of the metaphysical sense. Stern states that, when divested of its Freudian positivism, psychoanalysis contains a movement toward personalism.

Freud's renunciation of metaphysics in favor of science has been continued and reinforced by some contemporary theoreticians. Feigl (12) lumps theology and metaphysics with magic, animism and mythology and describes them as "remnants of and regressions to . . . prescientific thought patterns." He condemns the "something more" philosophy as a "seductive fallacy" and rejects the assertions of transcendent theology and metaphysics as "largely emotive."

Psychotherapy as Applied Science

The practice of psychotherapy plunges psychology into metaphysical issues. There is general agreement that science cannot determine values. The function of science is to observe, describe and classify what *is,* but not to decide what *ought to be.* Psychology, as long as it remains a pure science, does not make judgments of value. It is when turning to treat the maladjustments of human personality that psychology moves away from the canons of scientific precision and ventures into the realm of values.

The transition from a pure to an applied science involves a value judgment of major consequence. Such a judgment presumes to differentiate between illness and health, and proposes to use scientific knowledge to

displace the one in favor of the other. In psychotherapy, psychology as a science thus becomes the servant of the ethical judgments and, in some measure, the value system of the therapist. As a healer, he seeks the recovery of his patient, sacrificing the neutrality and objectivity of the scientist for a stake in the outcome.

The application of psychological knowledge by one person to modify the attitudes and ideas of another involves the formation of further value judgments as to the need, the goal and the method of therapy. The counselor may be called upon, for example, to assist a person who is troubled by conscience. Is this illness or health? Is *any* trouble with conscience compatible with health? If so, how much? And if too much is present, how is the pressure of conscience to be abated? How much sensitivity of conscience should be left when the end-point of treatment has been reached?

In an effort to stay close to its scientific base, psychotherapy has concentrated upon technics of uncovering the patient's conflicts, upon analysis of interviews and upon theories of personality organization. The patient, on the other hand, is struggling with metaphysical concerns: What is the good life? Where does it lead? How much freedom does man have? Are the claims of religion illusion or are they insight into transcendent reality? Before these questions science stands silent, claiming no competence in matters of ethical discrimination, moral responsibility, and ultimate destiny.

Not everyone is willing to concede this inherent limitation in the nature of science. There is confidence that science will ultimately be able to provide a full explanation of the phenomena of the universe, including human behavior. This faith is responsible for most of the opposition toward permitting metaphysics to complement the incomplete world view that science now offers.

Freud proclaimed his loyalty to "the scientific *Weltanschauung,*" not only staking out "the spirit and the mind" as proper objects of scientific investigation, but specifically rejecting religion and philosophy as collaborators in truth-finding. In this broad repudiation of philosophy, Freud was merely electing a different metaphysical viewpoint and enunciating an impassioned *credo* in the philosophy of scientism.

Feigl (12) similarly scorns "the sham completeness metaphysicians procure for their world pictures by verbal magic" and declares that it is a sign of maturity to be able to live with an unfinished world view. To proclaim such an affirmation of faith in the ultimate adequacy of science is to close the gaps in a science-centered *Weltanschauung* by philosophical scaffolding and to crystallize a unique value system. The unfinished world view is an abstraction. Commitment to something is necessary to existence. Even to repudiate metaphysics is to affirm a significant metaphysical position.

There are many who doubt that science will ever be able to offer a complete world view. Conant (10) expresses this viewpoint:

> As to the unifying materialistic World Hypothesis, my doubt stems from its manifest inadequacy. As a conceptual scheme attempting to account for everything in the whole universe, it seems to me unsatisfactory because it is incomplete. It fails to provide for the altruistic and idealistic side of human nature.

Freud declared that, since psychoanalysis is a part of science, it has no concern with judgments of value. It is no less valid to say that psychoanalysis, psychotherapy and counseling cannot be purely scientific, even though they are grounded in an empirical psychology, since they inescapably involve human values. The limitations of science are apparent wherever human autonomy becomes a variable in a problem.

Zilboorg (49) recognizes that the therapist cannot avoid encounter with philosophical, ethical and moral issues:

> Suffused with anxiety . . . man again is forced to contemplate what it is that he is, what it is that he wants, what it is that he ought to want, and what his place is in relation to his fellow man individually, to society, to himself as an autonomic person. These are ontological, metaphysical and fundamentally religious questions. A psychoanalyst, more than any other professional man, must cultivate a philosophy of values.

Neurosis and Weltanschauung

The scientific framework in which any exploration of neurosis and anxiety begins is soon found to be inadequate to encompass all the phenomena, implicating as they do the values and the world view of the patient.

Masserman, who has produced what he calls "experimental neurosis" in animals, cautions against the drawing of sweeping identities between his experiments and "the almost incomparably more complex dynamics of clinical psychotherapy" (23, p. 458). In the treatment of neurosis, Masserman departs widely from the experimental approach to recommend that the therapist enter into the patient's "personal universe of desires, meaning, values and actions" (23, p. 488).

Rioch (34), in a review of "experimental neurosis," acknowledges that the degree of complexity, modifiability and variability of human behavior is of a different order of magnitude than that in lower forms and refers to Harry Stack Sullivan's contention that anxiety is limited to human beings.

Efforts to understand neurosis apart from an ontology of anxiety have been disappointing. Even after the creation and unrestricted manipulation of his metapsychological constructs, Freud (16, p. 92) concedes:

> We find ourselves abruptly confronted, once again by the oft-repeated riddle: What is the source of neurosis, what is its specific,

underlying principle? After decades of analytic effort this problem rises up before us, as untouched as at the beginning.

Shoben (37) formulates a theory of neurosis based upon experimental findings and learning theory. His view of neurosis as a consequence of defective social learning fails to deal with the concept of conscience and superego, and identifies guilt with anxiety.

Mowrer (25, p. 483) draws upon both learning theory and Freudian concepts to elaborate his concept of neurosis, concluding that neurotic persons suffer because they have repudiated their own moral strivings. This makes the undoing of repressions preeminently a moral enterprise.

A similar view was advanced by Pfister (28):

> . . . The repressed conscience plays a still more troublesome role than the known conscience . . . There consequently remains nothing but to purify the known, and, very often, too, the unknown conscience. In every psychoanalytic transaction deserving of the name, it is of great importance to replace the ill-advised with a clear and noble-piercing voice of conscience.

Stekel (39), another of Freud's early pupils, described neurosis as "the disease of a bad conscience" and recognized that somatic complaints could have a similar origin:

> Important is the fact that the voice of conscience may find bodily expression, this being what we call somatization. . . . The psychotherapeutist, taking his patients by the hand, must help them to restore the ideals which, deliberately, or under compulsion, they have destroyed (40).

May, after a detailed examination of the various concepts of anxiety offered by Freud and by the deviant schools of psychoanalysis, formulates a broad definition of anxiety as "the apprehension cued off by a threat to some value which the individual holds essential to his existence as a personality" (24, p. 191). He concludes, "The system of value on the basis of which one confronts normal anxiety . . . broadly speaking . . . is the person's religious attitude toward life" (24, p. 230).

Winkler (44) argues the inadequacy of the leading psychological doctrines of man. Freud saw man as a natural organism, Adler viewed him as a social being and Jung emphasizes him as an individual. "In addition to this," Winkler continues, "he is also a person in the philosophic and theologic sense, and he relates as an individual to the transcendental reality. He can also fail in this regard, producing that which may be labelled 'existential neurosis.' "

Frankl (14) believes that every man has a will-to-meaning, the frustration of which produces existential neurosis. His logotherapy aims to revise the defective world view in terms of meaning and value. "Patients themselves bring us philosophical problems," Frankl writes. ". . . The

proper diagnosis can be made only by someone who can see the spiritual side of man."

Progoff (30) traces the progressive emergence of this recognition through Freud, Adler, Jung and Rank. He writes,

> Their psychological investigations led them to a realization of the fundamentally spiritual nature of man. . . . They came in other words, to the metaphysical foundation of life that underlies psychology. . . . Psychological work fulfills itself only when it goes beyond psychology.

While psychological theory is moving to recognize the necessity of active encounter with the patient's value system, a parallel current is influencing the practice of psychotherapy. Pumpian-Mindlin (31) traces the ten-year evolution of practice in a mental hygiene clinic through various stages during which different emphases were found inadequate and dropped, one after another. The expression of hostility by the patient, the giving of love and affection by the therapist, the offering of psychodynamic interpretations and, finally, attempts at ego-integration, were all pronounced "not enough." In the continuing search for a more adequate approach, Pumpian-Mindlin concludes, "We must examine our culture and our values and those of our patients. We must see how these affect the 'self,' the total person."

A similar awareness is apparent on a social scale. Schindler (36) holds that many personality disturbances are caused by "confusion on a spiritual level," growing out of cataclysmic events in the past few decades that have brought the fundamental questions of human existence to the psychiatrist's attention. May (24, p. 109), in applying Mowrer's concept of neurosis, observes: "The repression of guilt feelings, with its concomitant generation of neurotic anxiety . . . in some ways is pervasive of our culture as a whole." This view is supported by Riesman (33), who comments:

> Increasingly today, this new type of analytic work with people who are not obviously ill—whose "symptom" is their malaise, their whole way of life—people who are troubled about moral issues, or who ought to be troubled about them, forces analysts to become concerned with problems of casuistry, of values, as part of the very task of therapy.

Tillich (43) finds that the common denominator in all theories of anxiety is the awareness of conflict between structural elements of the personality. Only in the light of an ontological understanding of human nature, he believes, can a consistent and comprehensive theory of anxiety be formulated. In the interpretation of human existence, the psychotherapist can benefit by collaboration with the philosopher and the theologian. Tillich views existential anxiety as basic, growing out of the three-fold ontological threat of death, meaninglessness and guilt. These belong to existence and cannot be eliminated. Existential anxiety is properly the object of priestly concern, while pathologic anxiety is the concern of the psychotherapist. The goal of both professions is to help the patient achieve full self-affirmation. They may collaborate fruitfully, but neither should try to replace the other.

Although he emphatically denies its validity, Freud (15, p. 206) acknowledges that religion possesses a philosophy of incomparable strength and consistency, that has successfully resisted severe criticism. Religion, he concedes, exerts power over the strongest human emotions. A religious view of the universe adds strength and stability to personality, Freud acknowledges, even while he is trying to refute religion's claim to truth by arguments from psychoanalysis.

Freud's attacks have undoubtedly contributed strongly to the reluctance of psychotherapy to appropriate and apply the insights of religion. This unwillingness to deal with religion is discussed by Gordon Allport (4). Noting that "psychologists write with the frankness of Freud or Kinsey on the sexual passions of mankind but blush and grow silent when the religious passions come into view," Allport argues that the psychologist has no right to retire from the field, since two-thirds of the adults in this country regard themselves as religious people and nine-tenths affirm belief in God. Seventy per cent of the 500 college students questioned by Allport felt that they needed some form of religious orientation or belief in order to achieve a mature philosophy of life. Seventy-five per cent of the women and 65 per cent of the men acknowledged praying, many every day.

In spite of Freud's professed atheism and his violently anti-religious writings, Zilboorg (50) believes that he had "unconscious, intense, positive religious leanings." There is a note of wistfulness in one of his letters to Oskar Pfister, a Swiss Protestant clergyman who was one of the earliest practitioners of psychoanalysis. In the letter, Freud complained about the kind of patients who came for analysis, describing them as "often very poor material." "You, on the other hand," he wrote, "have young people with recent conflicts who are attached to you personally, and who are in a suitable state for sublimation and indeed for its most convenient form—religious sublimation . . . You are in the fortunate position of leading them on to God and reconstructing the conditions of earlier times, fortunate at least in the one respect that religious piety stifles neurosis" (20).

Freud's observation that religion can give strength and stability to personality and can "stifle neurosis" is not bound to the hypothesis that he devised to explain the fact. By "genetic analysis" he arrived at the conclusion that "the religious *Weltanschauung* is determined by the situation that subsisted in our childhood" (15, p. 210). Religion provides ethical precepts and a sense of protection, Freud decided, by preserving childhood attitudes.

This explanation has two flaws: Freud's defective understanding of religion, and his neglect of one of the most significant aspects of personality, purposive striving.

Freud's anti-religious writings indicate a lack of any real acquaintance with religion. Immediately after the appearance of *The Future of an Illusion,* Pfister (29) replied with a paper giving effective answer to

Freud's criticisms of religion. Dalbiez (11) has offered a comprehensive criticism of the logic and philosophy inherent in Freud's position. In biographies and critiques, friend and foe alike have referred to the evidence for unconscious bias in Freud's anti-religious pronouncements.

Allport (3, p. 92) warns against "the trivial view that holds adult religion to be merely a repetition of the experiences of the child," adding, "The most comprehensive units in personality are broad intentional dispositions, future-pointed." This aspect of universal human experience, largely unrecognized by an empiricism that sees man as a passive being responding only to forces outside himself, is illuminated by the insights of religion. "While religion certainly fortifies the individual against the inroads of anxiety, doubt and despair," Allport continues, "it also provides the forward intention that enables him at each stage of his becoming to relate himself meaningfully to the totality of Being."

The stability of personality and resistance to neurosis that Freud observed and acknowledged in religious people thus has an alternative explanation more inclusive than Freud's hypothesis, because it articulates with major aspects of personality that he failed to include. Poverty in representing the future, in Allport's opinion, is the chief shortcoming of American psychology. Leo Alexander (1) also comments, "The concepts of ego and superego must be widened to include the will and the purpose as the key to responsibility. There is undeniable historical and social evidence for the existence of will and purpose in human affairs." Limitations set by the canons of scientific method and by the philosophies derivative from science have prevented psychology from recognizing or adequately studying these facets of personality.

The Therapist's Value System

Every psychotherapist is a philosopher of sorts. When the psychologist turns away from his measurements and statistics to deal with troubled individuals on a one-to-one basis, he leaves pure science behind. Becoming a participant in the healing process draws him inescapably into the realm of values. At this point, as Allport (5) has pointed out, "Whether he knows it or not, every psychologist gravitates toward an ontological position. Like a satellite he slips into the orbit of positivism, naturalism, idealism, personalism." Refusing, as Freud did, to acknowledge commitment to a basic philosophy, is to defend it less effectively than if it were consciously avowed.

Furthermore, the therapist's own value system is deeply involved in the process of psychotherapy. Developments in ego psychology have not abated metaphysical involvement. The therapeutic goal of psychoanalysis is described by Gill (18) in these terms:

> A progressive analysis from the surface to the depth; analysis of the defenses and the motives for defense; the development and analysis of the transference neurosis; a resolution of symptoms, and as complete a "structural" alteration of the neurotic aspects of the personality as possible.

The process is further elaborated with the statement, "The gross major decision is whether the defenses of the ego are to be strengthened or broken through as a preliminary toward a reintegration of the ego."

This view of psychotherapy makes it a prerogative of the therapist to decide what aspects of personality shall be dismantled, as well as the form and content of the restorative process. Here the personal philosophy of the psychotherapist may determine the pattern of reconstruction. Reorganization of his patient's personality cannot help but implicate the therapist's own value system.

Even apart from active intervention in the reintegrative process the therapist's value system exerts its influence. Wolff (46) in his survey found some therapists contending that treatment should consist of reshaping distorted value concepts, while others advocated exclusion of the therapist's values from psychotherapy as far as possible. Wolff (47) also reported that, while only 6 per cent of 43 therapists regarded change of values as a goal of therapy, 48 per cent believed that therapy does in fact directly transmit or develop value concepts in the patient. An additional 24 per cent thought that values have an indirect effect in therapy.

Rosenthal (35) commented after his study upon the changing of moral values in psychotherapy:

> It may be that the therapist communicates his values to the patient in many unintended, subtle ways, even when trying to avoid doing so. The patient, who is often sensitized to the therapist's every word and inflection, may be able to receive these communications, and because of his trust, admiration and respect for the therapist, may permit himself to be influenced by them.

The world view of the counselor apparently exerts its influence in ways unrecognized by either the patient or the therapist himself—in the selection of subject matter for response or discussion, in nonverbal cues if not by verbal expression. This was true even of Freud in the analytic situation. The account of Wortis (48) describes frequent manifestations of his misanthropy and pessimism. If only in subtle, inadvertent expression, the therapist's value system appears to be a constant factor in the relationship.

The therapist usually conceives of himself and is often represented as the detached, dispassionate scientist. A more realistic view would see him as an involved participant with an interest in the outcome, following a sectarian psychotherapeutic doctrine or combination of doctrines, the selection and practice of which are tinctured by his own basic philosophy of life.

The Therapist and Religion

Recognition of the role of the therapist's philosophy of life raises questions fundamental to the success of therapy. Can a therapist that denies the importance of supra-empirical factors in neurosis achieve an empathic relationship with a patient who is burdened with a sense of sinfulness? To

reassure such a patient that "this is not a moral problem but can be understood only with impersonal, objective, scientific attitudes (42) may lead in a direction opposite to improvement and insight.

If metaphysical concerns are at the bottom of many neuroses, to avoid the discussion of religion in psychotherapy, as Wolberg (45) recommends, may be to bypass the most significant area of conflict. Masserman (23, p. 494) advises assuring the patient that his philosophic or theological faith will not be challenged, confessing that "only in the early years of his inexperience and defensive dogmatism did he think it necessary to explore, let alone attack, the patient's religious beliefs or practices." This calculated inattention to an area of frequent personality conflict may easily overlook a greater difficulty for a lesser.

To ignore or minimize the field of metaphysical concern in favor of sexual conflict or any other predetermined framework may leave untouched the most important cause of difficulty. Reider (32), for example, tells how a patient called him ten months after treatment had ended to say, "I just wanted you to tell me that there is no such thing as hell where people go for their sins." He complied with a pontifical negative, giving no recognition that the patient's request expressed anxiety growing out of metaphysical concern that had been presented at the beginning of treatment, and that had obviously remained unresolved.

The responsibility for determining what religious attitudes are healthy or neurotic is a crucial one, certain to be colored by the therapist's own basic orientation toward religion. This is well illustrated by Casey's (9) citation of an analyst whose own unconscious resistance to religious appeal led to his opposing any religious adjustment by his patient. In the presence of such an attitude, the question of Arnold (6) is pertinent, "whether the therapist can correctly evaluate the resistance of a patient with whose philosophy of life he cannot agree."

Many psychoanalysts believe that religious beliefs and practices have a sexual origin and represent infantile emotions. Others regard religious concepts as benign but delusional. Can a therapist with such views enter into the personal universe of a religious patient's meanings and values to establish empathy on any other basis than as the discerning possessor of truth communicating with the naive victim of error?

The frequent concern of the religious-minded patient and his family over the therapist's attitude toward religion is not without relevance. The naturalistic orientation not only includes certain beliefs, but excludes others. In providing himself with one variety of philosophical stuffing "to stop up the gaps in the universe" (17), the naturalistic psychotherapist at the same time rejects those philosophies that are open-ended toward a reality beyond science. The patient's concern is whether such a counselor can be tolerant toward a world view that he regards as error, and can leave such a faith undisturbed during treatment. How many therapists will recognize and

acknowledge the error of attacking the patient's religious beliefs, as Knight (21) did in his analysis of a minister?

Doctrines of Man

The inability of science to provide a complete view of the universe is most apparent in its apprehension of the nature of human personality. There is no mature science of man; there are only doctrines of man. Science at its best provides a truncated view of man. Every doctrine of man includes a substantial body of theoretical assumptions. These doctrines vary from the biological emphasis of Freud with its destructive death instinct, through the deviant psychoanalytic schools that stress social and cultural factors, to those that postulate an inherent upward drive in man toward self-enhancement.

Somewhere between these extremes is the Jewish-Christian doctrine of man that recognizes both the potential for good and the tendency to evil in man's nature. In contrast to the relatively scant empirical data and unilateral focus characterizing most of the neonate doctrines of man, the insights provided by religion are supported by centuries of observation and experience, and deal with the full sweep of human existence.

The psychotherapist is not offered a choice between a scientific and an unscientific doctrine of man. Rather, the choice is among different views of man that are corollary to various philosophies. Most of today's psychotherapy is set in a context of naturalism or positivism. The empirical findings of scientific psychology are not bound inseparably to either of these basic faiths. Such a context is a psychology-plus-philosophy; there are other philosophies equally compatible with the science of man that may lead to a clearer understanding of the patient who is troubled by metaphysical concern. To quote Outler (27), for example:

> The Christian faith is at least an equal option for the thoughtful man. . . . It is at least as intelligible a faith, resting on at least as much experiential evidence and exhibiting a capacity to interpret the inescapable issues of human life in a fashion both more meaningful and truly profound. The truth claims of the Christian faith cannot be "proved." . . . But they can be tested by those who place themselves inside the circle of faith. . . . Moreover, the Christian faith can be an ample and hospitable context for the scientific enterprise, in all its proper dimensions and concerns.

The Thomistic affirmation is similar: "A truly comprehensible and tenable view of man is achieved within the Christian ideology" (8).

Among others, two factors have contributed to the growing congeniality between psychotherapy and religion. The first is an increasing insistence on the part of religionists that "psychiatry cannot adequately perceive the whole man without taking into account the contributions religion has made available for the search" (38). Coupled with some acceptance of this claim by psychotherapy is a measure of recognition that the synoptic view of man offered by religion is both comprehensive and

penetrating, its validity being supported by an impressive empirical background and maturity. As a consequence, the offices of the minister are being more widely utilized to augment the skill of the psychotherapist in the recognition of metaphysical concern as contributory to neurosis, and in the resolution of that concern through the resources of religion.

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RELIGIOUS ATTITUDES OF MALE NEUROPSYCHIATRIC PATIENTS: I. MOST FREQUENTLY EXPRESSED ATTITUDES

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The Inventory of Religious Attitudes was devised by the senior author as a method whereby information concerning the religious attitudes of Protestant, neuropsychiatric patients in a Veterans Administration Hospital might be ascertained more quickly and more effectively than through interview procedures. Further, the pattern of religious attitudes so obtained was to be utilized for more effective counseling with the patients and their families. Revised Form No. 1 of the Inventory was prepared and placed in use in November 1955, when the junior author became a part of the Study.

The Inventory consisted of 130 statements expressing religious feelings and attitudes. The following will serve as examples: "God treats all people in the same way," "There is no life after death," "Reading the Bible will assure eternal life." These statements were divided among thirteen sections; namely, God, Prayer, Immortality, Heaven, Jesus Christ, Parents, Failure in Life, Bible, Proper Use of Sunday, Wealth and Poverty, A Child's Death, General, and a section in which patients were asked to identify the statements which were to be found in the Bible. Patients responded to this Inventory by checking those items with which they agreed. As a part of each section, space was provided so that patients might write in some of their own feelings or attitudes about these specific subjects.

The procedure followed for the administration of the Inventory was this: newly admitted, Protestant patients were seen in a group once each week. All newly admitted patients reported to this group, except those who were considered by the Ward Physician to be too confused to fill out the Inventory; and an attempt was made to have these men included in a later group. Following a short interview, designed to secure rapport, the Inventory blanks were distributed and directions given for completing them.

This Study was conducted at the Veterans Administration Hospital, Leech Farm Road, Pittsburgh 6, Pennsylvania, and was partially supported by the Research Committee of the Hospital. Conclusions expressed are those of the authors and do not necessarily reflect the opinions of the Veterans Administration.

Each completed Inventory was then carefully analyzed for (1) clinical and (2) research purposes. For its clinical use, a report was written to summarize the patient's major attitudes towards religion, as well as conflicts, inconsistencies, and ambivalent feelings revealed. If permission to do so were granted by the patient, a copy of this report was made available to the professional staff of the hospital to aid them in understanding the patient and in planning the most effective treatment program. These clinical reports were utilized by the Chaplain Service of the Hospital in its individual contacts with patients and families, and in the setting-up of groups for the purpose of discussing religious beliefs and sentiments (the latter term used in the Allport sense; namely, ". . . an organization of feeling and thought directed towards some definable object of value" (1, p. 55).[1] For research purposes, the reports and Inventories were analyzed for the most frequently expressed attitudes, feelings, general religious sentiments and problems. A basic objective, kept always before us, was a search for insights and leads which would prove helpful in the religious counseling of Protestant, neuropsychiatric patients.

During the period from November 1955 to October 1956, a total of 139 newly admitted patients were seen. These men were all admitted to the Acute and Intensive Treatment Service of the Hospital. All Inventories were administered by the same person. Out of this number, it was found impossible to analyze or prepare adequate reports for 9 patients due either to their outright refusal to complete the Inventory or to their confused state. The most frequently expressed attitudes have been tabulated in Table 1. It will be noted that the number of attitudes exceeds the number of patients, since many of the patients expressed more than one attitude.

The attitudes tabulated in Table 1 will now be illustrated in order that a more vivid picture of the processes behind each one may be presented. They will be referred to by the letter symbol shown before each one in the table.

a. Patients here affirm that "God punishes us," and that "God sends floods to punish wicked people." One patient reported that, while in college, he had severe acne and ulcers, both of which (as he verbalized it) were punishments God had visited upon him for his sexual activities.

b. The same patient, referred to above, affirmed that "God loves us," and "God forgives," in addition to affirming the various statements dealing with God as a punitive Being.

c. A patient, who has not affiliated himself with religion, wrote that "it (religion) places too many restrictions against the natural things a man needs and desires." He also wrote, ". . . prayer never helped me . . . I don't know what to expect after death, but it does not worry me."

[1]A Manual for the Administration and Interpretation of the Inventory of Religious Attitudes, Revised Form II, has been prepared. A copy may be obtained upon request from the authors.

TABLE 1

ATTITUDES, FEELINGS, GENERAL RELIGIOUS SENTIMENTS AND PROBLEMS MOST FREQUENTLY EXPRESSED BY 130 PATIENTS TO THE INVENTORY OF RELIGIOUS ATTITUDES.

ATTITUDE, ETC.	NUMBER OF TIMES EXPRESSED	PERCENTAGE OF TOTAL
a. Concern over punishment, frequently tied in with feelings that their illness is a punishment for sins; strong guilt feelings	61	16
b. Ambivalent feelings and attitudes toward God; e.g., God perceived as both loving and punitive	24	6
c. Attitudes reflecting poor, inadequate, or non-existent religious training and instruction	58	15
d. Feelings that their "failure in life" (frequently associated with their illness) is associated with punishment for sin; feelings that, conversely, success is associated with orthodoxy	37	10
e. Magical, miraculous, superstitious elements most prevalent; "religious behavior" adopted for materialistic gains; religious immaturity as a central factor	48	13
f. Serious religious doubt; lack of faith	15	4
g. Severe sexual problems, associated with religion, as the central problem	5	1
h. Attitudes reflecting a distorted relationship with parents	22	6
i. Attitudes and feelings reflecting marital or premarital problems and disturbances which are related to religious feelings	28	7
j. Attitudes reflecting a serious search for a genuine faith	11	3
k. Attitudes reflecting a very shallow faith; confusion of religious thought; inconsistency of religious thought	60	16
l. Clear cut religious delusions reflected	12	3

d. As indicated in the table, the attitude that one fails in life as a consequence of divine punishment for sin was widely expressed. This attitude was reflected through patients' affirming that, "If we are failing in life, it is because God is punishing us for our misdeeds . . . and it is in accordance with God's plan."

e. This attitude was inferred by action of patients in affirming those statements which indicated that for them religion was something supernatural, something accomplished for them, which placed no responsibility upon them. A patient who affirmed this then added that membership in a church was "useful" because it bore prestige in the community. For another patient, the results of his Inventory indicated that his was a "gimme" religion on which he pathologically depended but toward which he felt no responsibilities or obligations.

f. One of the patients in the group—who had spent thirty-three months in a Korean POW Camp—reflected an attitude of serious doubt. He had originally affirmed the statement that "God treats all people in the same way," and then had taken pains to go back and register a strong disagree-

ment to the statement. Other patients reflected their doubts by indicating they did not know what to believe about immortality, the Bible, or Jesus Christ.

g. Severe sexual problems, with resultant profound feelings of guilt, stemmed from sexual drives or overt sexual experiences the patients could not accept or assimilate in their value systems. In one patient, an initial experience of intercourse with a prostitute while a freshman at college served the double purpose of motivating him for the ministry (the better to control his sex drive) and of leaving him with such an overlay of guilt that he abandoned his professional goal since he was "unworthy."

h. A distorted relationship with parents was particularly well illustrated by a Protestant patient who was very much determined to become a member of the Jewish faith. His father was Greek Orthodox, and his mother a Presbyterian. He had rejected his father, and his ethnic origins, by rejecting his father's Church—"It is a Church for foreigners!" He had also rejected his mother through rejecting her Presbyterian affiliation. Another patient reflected this distorted relationship by saying, "My own people's acts of selfishness made me too bitter to practice religion."

i. Marital problems relating to religious feelings were prominent. Frequently, these stemmed from mixed marriages. Dealing with the subject of punishment for sin, one patient emphatically insisted "then my wife will be punished for her sins"—which he identified as being those of infidelity.

j. This attitude is illustrated by a patient who did not attend Sunday School, and in his earlier years was "very doubtful of religion." Now, he has come to "believe more"; he reads his Bible and prays. He thinks of God, now, as being "basically friendly."

k. Confusion and inconsistencies in religious feelings were reflected through the affirmation of such contradictory statements as "there is no life after death," and "reading the Bible will assure eternal life." As will be seen from the table, these responses were numerous.

l. Clear-cut religious delusions accounted for a small percentage of the responses. One or two patients' replies will serve to illustrate this. In one case, the patient expressed the belief that God had called him to be a prophet and bring about peace on this earth. This seemingly was triggered by the guilt he felt over his participation in war. This same patient, likewise, believed he had the ability to heal. Another patient announced himself as "Son of my Father; I am Jesus Christ." To his Inventory, he signed the name Jesus Christ, followed by a cross.

Discussion

On the basis of this analysis of the accumulated data, a number of points may be discussed.

1. A sizable percentage of responses indicate a widespread inadequacy of religious training, and of shallow, confused, and inconsistent religious

thinking and feeling. By the very nature of the Inventory—dealing as it does with religious attitudes—we did not find in our group of patients the large number of persons (as reported by Boisen and Oates) who have no religious concern at all. In an extensive study of the case histories of 78 patients, Boisen (2) found 50 in whom no religious concern was expressed. Similarly, Oates (4) reported on extensive analysis of case histories and individual interviews and group contacts with 68 patients from Kentucky State Hospital. Of this number, 35 showed no religious concerns at all. In the study which we are reporting, those patients who exhibited a minimum of interest and concern in and for religion are to be numbered among categories *c* and *k*. In these two categories, we have the responses of individuals who have received virtually no religious training, as well as those whose training was weak and inadequate for the stresses of life. Also, in these categories, we have the responses of those who exhibit confusion and inconsistency in their thinking about religion which serves to weaken and dilute it, so that what results is a shallow and immature, almost a caricature of, religious faith. Again and again it was apparent that this caricature of faith held no power to revitalize spiritually the lives of the patients. The large percentage of these responses are at least indicative of a serious lack of adequate religious training in the homes and Sunday Schools of our nation. If, in some way, these institutions of our Protestant Christian faith are not challenged to accept their responsibilities for adequate and discriminating religious indoctrination of the principles of the Christian way, then we are in for some serious trouble in the form of personality breakdowns.

2. Concern about punishment, with its ramifications—i.e., God perceived as a punitive Being, and failure in life associated with punishment for sin—constitutes a large percentage of the total responses. This is a confirmation of Rutledge's comment (5) that, among the emotionally ill, we frequently find concepts of a primitive and punitive God. It is likewise a confirmation of the results of a study by Einar Nilsen (3), who analyzed biographical material stressing crises experiences in religion. He found evidence of a high correlation between the idea of a "strict" God and a "lowered self-evaluation," with a "subsequent narrowing of life's spaces and proneness to emotional instability and social maladjustment." This would seem to pose a major problem to theology and religious education; namely, how to interpret the idea of a just, righteous, and merciful God in such a way that—through the communication of this teaching—the distorted picture of a savage and primitive and punitive Deity does not emerge. A proper humility in regard to man's status in this universe is certainly conducive to mental health, but a "lowered self-evaluation" resulting in a lack of respect for and a pathological de-valuation of one's own capacities and powers can only result in emotional illness. While it is usually true that, as Dr. Southard (6) has stated, it is *how* a teaching is accepted that is more important than the teaching itself, it is likewise true that some "Christian" teaching is definitely not Christian and can have only an unhealthy

influence on an individual who already suffers from a weak ego. While a number of religious delusions were communicated through the Inventory, we found only one case of a clear-cut mystical identification as defined by Boisen (2).

3. By the very nature of the Inventory, we are not in a position to state categorically in what percentage of our replies religion was shown to be the precipitant factor in the mental illness of the patient. But we may infer from a perusal in Inventories and reports that in a few isolated instances this seems to have been the case. In one individual—in whom a severe sexual conflict was central—it was his perception of the religious implications of his sexual experiences that precipitated his illness. Much more prominent, however, is the conclusion that it was not religion per se that proved to be the precipitating factor, but rather that an inadequate, weak, and confused religious sentiment did not provide the inner strength sufficient for the individual to find other than a psychotic solution to his conflicts.

Summary

Revised Form I of an Inventory of Religious Attitudes was administered to 139 newly admitted Protestant patients on the Acute and Intensive Treatment Service of the Veterans Administration Neuropsychiatric Hospital in Pittsburgh between November 1955 and October 1956. Completed Inventories from 130 of the patients were analyzed as to the attitudes most frequently expressed, and these attitudes were illustrated by referring to individual Inventories. In general, it was found that (*a*) a large percentage of responses indicated a widespread inadequacy of religious training and of shallow, confused, and inconsistent religious thinking and feeling; (*b*) concern about Divine punishment was strongly reflected; and (*c*) an inadequate and confused religious sentiment did not provide sufficient inner strength to meet the pre-morbid emotional stresses of the patients.

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HE WAS IN THE PRIME OF LIFE

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"He Was in the Prime of Life" calls for a definition of this period of a man's life, and I am going to choose the years from thirty to sixty as those usually the most active and creative in man's activity. When an illness that appears to be hopeless fastens on to a man in this age group, what should the doctor do about it? What he *can* do, and what he *should* do, and what he *actually does* become a blend of ethics, socio-economic leverage, and emotional reactions of the physician in his relation with the particular patient.

There is no one answer or fixed pattern to cover our behavior under these circumstances. We might, at the outset, cite five examples that are so typical in medical practice that I would venture to say that any physician in general practice now has at least one such case under his care: (1) the sixty-year-old man with relentless congestive heart failure; (2) the fifty-year-old business executive with Hodgkin's disease and severe anemia; (3) the forty-year-old worker with chronic nephritis and a slowly deepening uremia; (4) the forty-year-old mother of three maturing children who has "arthritis" from metastatic carcinoma from a breast operation four years previously when she was told that it was a cyst; and (5) the thirty-year-old man newly married and found to have leukemia.

What to say? What to do? Our first duty, it seems, is to our patient; our next duty, to his family; our third duty, to society as a whole. I should like to discuss these three aspects of our duty.

The burden of decision and responsibility must rest with the physician who accepts the care of the patient. Once having accepted the patient, he is committed to do his very best to follow through. I think that often it is forgotten that we, as physicians, have the right to reject or accept. Oftentimes the emotional troubles and problems we get into lie in accepting the responsibility when we should say, at the outset, as the Chinese would say, "This is the kind of a case with which I feel I am not qualified. I advise that you seek and obtain another physician to handle the matter." Too

Part of a panel discussion on "Help for the Hopeless" held at a meeting of the Rhode Island State Medical Society. Adapted and reprinted with permission from the *Rhode Island Medical Journal,* September, 1956, Vol. XXXUX, pp. 494-497.

often we do not employ this technique. Although the task may be distasteful and difficult, it usually can be managed with patience and the revelations of time to those concerned.

First, it is important, I think, to consider the term "hopeless." It is a term that we use and we apply with the background of our knowledge of the situation, but certainly it is not the term to use before the patient or even the patient's family because I think that we should never deny some hope. We never know just what is around the corner. A story about the personal life of Dr. George Minot illustrates this point very clearly.

Dr. Minot was very ill with diabetes; this was in the early 1920's and before he had discovered that liver extracts and liver cure pernicious anemia. Just then came insulin, which rescued his life for his great contribution to medicine and his winning of the Nobel Prize. No one could have predicted the discovery of insulin at just this time, but I am sure that Dr. Minot was treated by wise physicians who took a hopeful attitude, although he was a severe diabetic.

The behavior of the physician is most important. I do not want to be pedantic, but repetition of even prayers seems helpful, so I would like to repeat the commonplaces that are sometimes forgotten in the busy day's work in the practice of medicine.

It is hard enough for relatives or friends to visit the hopeless, and it is even harder for the physician, because he enters presumably to cure illness and to save life. But here he has recognized defeat in the living person; it is only a matter of time according to his best diagnostic methods. How long will it go on? He can't tell how long it is going to be, but he can make a shrewd, clinical guess. That always leaves the element of hope remaining. Some physicians cannot accept defeat and avoid seeing the patient. I wonder if that would not be the point where it could be suggested that another physician be employed, with the physician admitting that he just cannot take it, and that he isn't built to do it. Perhaps the physician should face it honestly and say, "Can't you find somebody else who has the right temperament?"

And frankly, maybe the minister could do as well, with his ministerial calmness and simple words and phrases, bringing spiritual strength to the patient. Perhaps we do not often enough call upon the ministers. For the average man who does his duty has found that words of pity are out of place, that sugary tidings turn rancid, and that a casual or airy attitude that attempts to dismiss all thought of danger only disgusts the patient. The friendly, direct approach, with natural voice and acts, is best received. Many patients admire the physician who says little, but, by his strong, firm manner and gentle touch of the hand, conveys the deep companionship of man.

The starting point, then, of the professional care comes with the question: Shall you tell the adult patient the truth?

For years and years the usual course has been for the family to ask the physician to deny that anything is seriously wrong and to maintain that there is nothing to worry about. This is, instinctively, the first reaction of the family. Too often the physician has fallen into this trap and agreed, perhaps because in some college course he was trained to do this, and also because he was so busy learning the patterns of disease in medical school and during his intern years that he did not receive any teaching or preceptor training in these subtleties or in the art of the practice of medicine.

I think that we can criticize our medical schools for being lax in this area of teaching. I am not aware of such teaching coming to the medical students of Harvard except by contact with the physicians during the last year of school on the wards and during bedside care. Too often this is pushed to the Senior on the job; the Visiting Man is too busy overseeing the whole program. This year (1956) we did meet with our students and had a talk covering this very area, and I think this marks a real advance in meeting the problem that we have to face.

The patient who feels himself slipping in health and strength or who, after diagnostic procedures that may include surgical exploration, finds himself returning for prolonged X-ray treatments or frequent visits with the doctor, can hardly be so stupid as to believe such naivete on the part of the doctor or the family that everything is "all right" and that he is going to get well, and don't worry about that, or we will talk about that next time. His wife may be irritable and break down and cry easily, and he knows that she has been given bad news. His business partner may come in and ask such pointed questions about future management that the patient has little doubt of the gravity of his illness. But Dr. Cheerful forces a smile, slaps the back and utters nonsense while he avoids looking the patient in the eye.

Dr. Richard Cabot rocked the medical profession a half century ago when he began to tell the patients the truth, especially about cancer. The debate has been bitter but gradually the affirmatives have won a majority.

In 1953, Otis R. Bowen of Indiana conducted a survey of 500 of his patients to determine if they desired to know whether or not they had a cancer. So far as I know, this is one of few scientific approaches to a problem which obviously has a great personal impact. He was surprised to find a large majority of his patients felt that the patient could not be fooled and that they desired to know whether or not they had a cancer, and that many of them desired that their families should know. Many even expressed a desire to have cooperation between their physician, their minister, and close relatives in handling the situation.

One interesting point was that the age group up to thirty-five expressed

greater trust and confidence in their physicians than did the older age groups. To me the inference is clear: the older people had too often found doctors lying; they had lost faith in physicians through experience. Never before have we as physicians had such need to maintain or restore faith in our behavior.

I believe the "hopeless" patients have the right to know enough of the truth that they can so order the balance of their lives that their days can be lived out with dignity and to the best advantage of the whole family. My belief is that honesty is best; the truth should usually be told, but individual tact avoids saying the unnecessary, or too much.

Now, let us deal with the family. Many times I have seen a peace and satisfaction come over a family united in the truth, when previously there had been outbursts of pent-up emotions, much sidling out the door to talk to the doctor alone, and evasive answers to direct questions.

Evasive tactics instill suspicion and poison the mind. Let us take the example of the sixty-year-old person with congestive heart failure; he may be hopeless if he has lost the desire to live. If he has a burning desire to live, and a usefulness, then by sticking religiously to a form of treatment he may live on for many years. He needs the frequent advice and encouragement of his doctor. The day may come when he is tired of it all and says, "What's the use of this struggling? Why not let Nature take its course?"

What can the physician say? It is a tough situation and it puts the physician on the spot. He has but one answer, that he can help the patient; sometimes the best argument against such passive suicide is that the sick one is needed and loved by someone in the family, someone he should not desert.

The future of the family has to be considered. I have recently finished two months of visiting on the wards of the Massachusetts General Hospital, and in this time have seen patients coming back to our Service because they seemed to be unable to find the support of a wise generalist in medicine.

J. A. had relentless Bright's disease and, with crises of hypertension and uremia, he would demand to be brought back to our hospital. Here the eager House Staff made heroic efforts to prolong his life. Each time the electrolyte pattern was restored, and he miraculously went home to have death take another little bite out of him. Finally, on his sixth return, he died. The family received a total bill of $1,960.00. He had sacrificed the education of the eldest son. Joe didn't mean to do it. A good family doctor would have avoided this wasteful hospitalization. In retrospect, I believe our Social Service should have found a sympathetic general practitioner who could have relieved Joe's anxiety and organized his personality to make him live comfortably but more effectively for his family.

PACIFIC SCHOOL

No one could cure him. The physician in such a case consults with the family first. They may say, "Spare no expense; keep our Joe living." But that is an emotional response that is given often without reference to financial reality. The physician must weigh the facts carefully and make the decision that he deems correct, but one that will spare the family a later sense of guilt.

Denying the heroic or the ridiculous is often part of the doctor's job. But an equally important job is to convince the family that all possible methods of reasonable medical practice have been applied in his case. When the final day arrives, the family must not suffer the belief that they have failed a loved one, but rather that they have done all that could be done. It requires patience and careful explanation.

One valid criticism of the general practitioner in such cases is heard from the family which complains that "he is too busy." They want to talk things over, but they find that their doctor is either hat-in-hand, backing toward the door to make his next call, as if the next case could possibly be more important than the life there in the balance; or they go to the office but find the place so crowded and so hurried that adequate explanations seem impossible.

Then comes their next logical step: "Well, doctor, should we take him to *X* Clinic or call a specialist?" The reactions of the generalist to this are varied. At first, he may become angry because his attempted explanations have failed. Or he may become sulky because he feels that the family doubts his medical competence or judgment. Either reaction, to me, truly shows an unfortunate attitude for any physician to assume. The civil courts have long assumed that it takes twelve men or a superior Judge to pass judgment on even much lighter matters than the very continuation of a person's life. A well-chosen, single consultant or a brief period in the hospital, including consultation, may only give supportive evidence to what the physician already knew, but it tempers the icy thoughts within the family and makes future management easier. He has treated the anxiety of the family or the patient, a treatable condition, when the disease itself is untreatable. This, too, is the doctor's job.

And now we come to the relation of the patient to society as a whole. A question we must face is: "Is physiologic life sacrosanct?" But, as my friend, Doctor George Crile, has questioned: "When do we save one-half a life?" There is no answer to this question, for it is deeply imbedded in a fluid medium of shifting emotional reactions of both patient and physician. This medium has a congealing point slightly below religious heat, and a melting point that cannot escape the blasts of pseudo-scientists in search of personal fame and another paper.

Medical quackery is no longer practiced by kerosene light off the tail end of a wagon; it is sometimes clothed in grants of money and takes place in the scientific aura of some otherwise honest institution.

The surgical attacks on disease have produced brilliant results in our time, and we have seen hopeless cardiacs restored to work; we have seen lung cancers removed; we have seen vascular systems repaired; and we have watched the brain pierced with percentile improvements. But now and then this enthusiasm to destroy disease has led to such mutilation of the person and consequent dependency on society that I cannot assign it to an ethical place in medical practice.

I have in mind a forty-five-year-old man on our ward who had an extensive cancer of the jaw and who was operated upon and then heavily radiated. The cancer is gone, but the net result is that he lives, unable to speak or wait on himself; he is fed through a Penrose tube because what he would swallow would otherwise go into his lungs. He cannot live long, but, while he does, he will be an unreasonable burden to society and a torment to himself. But there is no cancer.

I have had to watch this man every day on my rounds for the last two months. I can only say that in such a situation only the physician's good judgment can decide how he is going to handle his individual case.

In closing, I give you my personal philosophy, which is that we, as physicians, have at times the duty to be present at the end of a life, even though untimely, and that this duty should be done with grace, without pain and without expensive, frantic attacks against a hopeless disease process. Finally, I would add that pithy, but much used and excellent, quotation: "O God, grant me serenity to accept the things I cannot change, courage to change the things I can, and the wisdom to know the difference."

THREE QUESTIONS IN PASTORAL COUNSELING: A REPORT

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In the fall and winter semester of 1957-58 the Washington School of Psychiatry conducted a seminar for ministers. The purpose was to clarify underlying assumptions and principles upon which ministers conduct their counseling. In the course of case presentations, more perplexing questions than assumptions and principles were revealed. Three questions, together with some tentative answers which the seminar members worked out together and found useful, are outlined in this paper.

Question: What should be the minister's role when he counsels with his parishioners? Should he judge, advise, guide, heal, interpret, or listen acceptingly?

Answer: Each minister would be able to answer this question more easily for himself on the basis of his own particular training, inclination and character, if it were not for two main difficulties.

1. The whole question of role is a disease of modern life, not peculiar to the minister as counselor. The disease consists in the idea that we ought to *know* in advance how to behave in a given situation just the way an actor knows when he starts his evening performance. We think that there is or should be a role of father, mother, doctor, teacher, etc., which we should assume in order to be a good father, mother, doctor, teacher, etc. If we study the distrust of spontaneous behavior which is implicit in this idea, we can gradually become less distrustful and less in need of playing a role.

2. The minister is often not clearly aware of what his parishioner is asking of him and may unconsciously share the false expectations which the other has. Many people come to the minister implicitly asking him to be first judge and then policeman, i.e., to enunciate and enforce the law, civil or moral. The unspoken, and sometimes even spoken, demand is that the minister read the riot act to an erring spouse or to objectionable neighbors. Paranoid people frequently make this kind of request. Others, especially women, come expecting the minister to be an ideal father or an ideal spouse. Since the minister represents the authority of the church, it is

easy for people to confuse him with God and to expect him to act like Him. The minister can find a great deal of relief by bringing such false expectations into his own clear awareness. Then he will cease to share them and will not suffer from the anxiety which sailing under false colors usually arouses, especially when it is not entirely conscious. If a man is expected to be a policeman and he *is* a policeman, he does not have any psychological difficulty. He may be shot in line of duty but he knows what he has to do. But if he allows someone to believe that he will act as a policeman when he will not and cannot, he becomes uneasy. How much more is this the case when someone believes he will act as God!

Having disabused himself of such grandiose notions to the best of his ability, the minister will use his skill and his tact to clarify the matter with his parishioner. He cannot simply tell him. He will have to elicit his expectations and then let the parishioner experience their falseness. The latter can live through his disappointment and will be more receptive to that which he can legitimately expect from his minister—namely, an honest encounter with another human being who has the will to help and who has thought quite a bit about human suffering. The more skilled the minister is and the more he has developed as a human being, the more valuable this encounter will be. But he cannot give more than he has. Even if what he has is little, relatively speaking, it is a great deal if it is given honestly. This is what Martin Buber is talking about in his exposition of the meeting between man and man.

Question: How can the minister fulfill his obligation to be of service to a troubled parishioner when the parishioner's demands are so great that they interfere with the minister's personal life or with his other duties?

Answer: This question arises in large part because it is harder for a minister to say no to a plea for help than it is for almost anyone else, especially when the plea comes from a soul in distress. Two considerations may alleviate the difficulty if they are kept clearly in mind.

1. Acceding to the request of a demanding parishioner that the pastor "please just come by once more for a few minutes right away" is no more in the ultimate interest of this parishioner than it is in the ultimate interest of a child to buy him every toy in the store. The child cannot play with all the toys and the demanding parishioner cannot make real use of continued appeasement. So long as the minister allows himself to become a wailing wall upon which aggrieved spouses, parents, etc., can pour out their complaints without end, the aforesaid spouses, parents, etc., will never entertain the notion that they themselves and their own attitudes might be at the root of the trouble or that they themselves might do something about it. Firmness on the minister's part in reasonably frustrating unreasonable demands is educative to aggrieved complainers as it is to children.

2. It is natural that the minister should like to be considered by his congregation a kindly, accessible person. He likes to consider himself this way, too. It is unpleasant if even a few of his parishioners think of him as a child thinks of the parent who is depriving him of something he wants. Here the minister has a decision to make in principle between two possibilities.

The one is to use his full energies to preserve a consistent image of himself in his own mind and in that of the whole congregation as an all-giving, kindhearted, selfless person. In that case it is inevitable that at least one of the following three things will happen: (1) He will get an ulcer, a heart attack, or some other disability. (2) His wife and children will suffer the fate of an essentially fatherless family. (3) Some part of his church program will be neglected.

The other possibility is to permit some people to dislike him, disapprove of him, and consider him coldhearted and selfish; and to permit himself to recognize that in some ways and on some occasions he *is* coldhearted and selfish. If this thought does not frighten him, he will gain in serenity and, on balance, his family and congregation will benefit.

Question: If the minister hears, through a third party, that a member of his congregation is in need of counsel, should he go to this member even though his help has not been asked?

Answer: This question arose in the seminar out of a difference of opinion among the members. Some were inclined to seek out any parishioner who was known to be delinquent in behavior and to try to reach him through Christian teaching. Others thought that this was a futile procedure and that counsel could be used only if it was sought. The question goes to the heart of what counseling can accomplish and on what basis it can be undertaken. Even a partial answer must first distinguish among different types of parishioner.

1. The person who *would* ask for counsel if he knew if were available. In his case there is no special problem as soon as he is informed.

2. The person who is too shy or proud to ask for help. Many people like this can be reached with a little tact. At least the door can be left open with a statement by the minister of willingness to help.

3. The person who rejects counsel even though he is obviously in need of some kind of help. The extreme cases in this category are paranoid and psychopathic (sometimes now called sociopathic) characters. Case histories known to religious as well as psychiatric groups bear witness that it is possible to help people of this kind. But it is an arduous task, not to be entered into lightly. Failure has to be envisioned as a probable outcome. Some ministers have a special bent for working with these cases. Those who do not might better use their energies where they will be more effective.

But among the parishioners who do not accept the minister's well-meaning counsel are many who are neither paranoid nor psychopathic. They are ordinary citizens who have fallen by the wayside in this or that respect and whose behavior is causing concern to family or friends. As members of a congregation, they have given lip service to Christian doctrine. "How then," some of the seminar members asked, "can we give them the motive power to do what they know they should do and we know they should do? That is the question we put to psychiatry."

The question, posed in this way, is unanswerable from a psychotherapeutic point of view, for the psychotherapist does not claim to know what his patient should do. Nor does he know how to give a person the motive power to do anything.

The underlying assumption of most psychotherapy can be summarized as follows. People suffer from psychological disorders because they are estranged from large aspects of themselves. This estrangement is sometimes called repression or dissociation. If they can be helped to be more fully aware of these unknown aspects of themselves, they will become better integrated, more whole.

If the ministerial counselor seeks this kind of integration for his parishioner, he will find the techniques of psychotherapy useful in attaining it. But if he seeks to make his parishioner conform to a certain moral code, psychotherapy has little to offer him. As a matter of practical fact, the man who lives in relative peace with himself usually lives a life which is beneficent to others. But there is no guarantee that his behavior will conform to any particular kind of morality.

Thus the question of whether the minister should offer help where it has not been asked becomes a question of the minister's goals, which will determine both what he does and how he does it. If he wants to influence his parishioner's behavior in a certain way, he can probably do this, at least in some cases, by using the pressure of his office, by subtle threats of punishment or subtle promises of reward. If he wishes to assist at his parishioner's growth, the best he can do as a counselor is to wait with his door open.

For both of these goals, the minister has at hand an instrument which the ordinary psychotherapist does not possess—namely, the church as a community and a fellowship.

COMMUNICATIONS

Freud Revisited

Thirty-two years ago, at the age of 72, Sigmund Freud wrote *The Future of an Illusion*.[1] It is a brief essay on the relation between religion and culture. The book was not well received. The subject had been an early interest of Freud, and this book represents an attempt to extend the psychoanalytic method in its maturity to a problem Freud felt in his youth. Consequently the method fits the problem only with a number of difficulties which cannot be resolved. It may be of fresh interest today to reiterate some of these difficulties.

Freud's real thesis seems to be this: "I am prepared to defend the statement that culture incurs a greater danger by maintaining its present attitude to religion than by relinquishing it."[2] In the hope that he can persuade men to hold the same point of view (though he is by no means naive in his expectation of success), Freud undertakes to show the origin of religious ideas. His method is an extension of psychoanalytic presuppositions to the cultural scene as a whole. He writes, "religious ideas have sprung from the same need as all the other achievements of culture: from the necessity of defending itself from the crushing supremacy of nature."[3] Moreover, "man makes the forces of nature not simply in the image of men . . . but he gives them the characteristics of the father, makes them into gods, thereby following not only an infantile, but also a phylogenetic prototype."[4] Because this represents the infantile ego looking out upon the world, as it were, from within its Oedipal conflict or a failure fully to resolve it, two things follow: (1) religious aspiration is one of the most dynamic parts of "the psychical inventory of culture;" (2) religious ideas are illusory. Freud writes, "we call a belief an illusion when wish fulfillment is a prominent factor in its motivation . . . disregarding its relations to reality, just as the illusion itself does."[5] Further, "religious doctrines . . . are all illusions, they do not admit of proof, and no one can be compelled to consider them as true or to believe in them. Some of them . . . we may compare . . . to delusions" (in which the conflict with reality is essential).[6]

A good example of the sort of thing Freud is talking about is the "divine" commandment not to kill. The Oedipal complex is at the root of this commandment. Freud accounts for it thus: "the slaughter of the primal father . . . evoked an irresistible emotional reaction, momentous in

[1] Liveright, New York, 1953 edition.
[2] *Ibid.*, p. 61.
[3] *Ibid.*, p. 36.
[4] *Ibid.*, p. 30.
[5] *Ibid.*, p. 54.
[6] *Ibid.*, p. 55.

its consequences. From it arose the commandment: thou shalt not kill . . . confined to the father-substitute (God) . . . later extended to others . . ."[7]

Freud marvels: "the stock of religious ideas contains not only wish fulfillments, but also important historical memories. What matchless, what abundant power this combination of past and present must give to religion!"[8] But it is because religion is tied to the past that a culture which is to advance must throw it off. There is only one danger in throwing it off: something new must be found to compensate the masses for their daily round of privation.

This and other questions Freud never answers. He never really decides what the ultimate cohesive factor of society is. He never resolves the argument between reason and the id, though he recognizes that reason is a weak god.[9] The reasons for these and other difficulties lie in the fact that psychoanalytic therapeutic discipline does not extend itself to philosophical thought without ambiguity. When it does so, it leaps the gap between therapy and philosophy by a non-scientific route. An example illustrates this.

"We do not . . . tell others of this rational basis for the murder prohibition; we declare, on the contrary, that God is its author . . . By acting thus we invest the cultural prohibition with a quite peculiar solemnity, but at the same time we risk making its observance dependent upon belief in God. If we retract this step, no longer saddling God with our own wishes, and content ourselves with the social justification for the cultural prohibition, then we renounce, it is true, its hallowed nature, but we also avoid endangering its existence."[10] What this says is that Freud feels it unsafe, because it is unscientific, to have a perfectly rational social law made unacceptable by religion.

Freud's anxiety on this score would make a questionable psychoanalytic deduction. It is based upon a then-prevailing misconception by which it was thought that science and theology were in conflict. This was due to theology's confusion, not to that of science. To Freud's bias we can add a distinct hostility to a generally other-worldly religion (understandably, since it appeared to flee the problem of improving this world, which was Freud's first love). On the one hand, his hostility toward the Roman Catholic Church accounts for his inability to see the difference between "faith" as relationship and "the faith" as a proposition of dogma. In most of what he says he is really taking issue with "the faith." On the other hand, Freud was contemporary with the growing influence of Schleiermacher, who undertook to do what Freud detested most: synthesize and compromise religious doctrine to theories of modern society, postulated

[7] *Ibid.*, p. 74.
[8] *Ibid.*, p. 75.
[9] *Ibid.*, p. 95.
[10] *Ibid.*, pp. 71-72.

upon what to Freud was no doubt a naive understanding of the emotional life of man.

So much by way of an attempt to understand Freud's thought and times. How valid is his thesis for religion? For Christianity?

First, religion: What is religion? One time it seems to be the projection of the human response to the Oedipal situation. Another time it seems to be a system of dogma. This double meaning is apparent in the following quotation: "Thus religion would be the universal obsessional neurosis of humanity. It, like the child's, originated in the Oedipus complex, the relation to the father. According to this conception one might prophesy that the abandoning of religion must take place with the fateful inexorability of a process of growth, and that we are just now in the middle of this phase of development."[11] "Religion" here is not clearly identified; consequently Freud appears to be shadowboxing. What is it he really opposes? This illustrates what happens when a man pushes therapeutic analogy of the religious response into the position of a metaphysic: the analogy breaks down. When it fails the only recourse is to fall upon what is discreditable from some other point of view, such as popular Roman Catholicism or Schleiermacherian Protestantism. From the above it should be clear that Freud's thesis is valid only to the limited degree that it describes the psychodynamics of religion. It cannot serve as a metaphysic.

Second, Christianity: The criticism above applies also to the validity of Freud's thesis with regard to Christianity, though the latter is not discussed in this essay. Because he wishes to make religion serve culture rather than the other way around (if religion cannot be "outgrown"), it is impossible for him to experience anything of the "I-Thou" quality of the religious experience. Least of all, then, is Freud in a position to recognize that in Jesus Christ God reveals himself as the kind of diety which has appeared in concrete to identify the proper subject of man's universal "obsessional" need. In Christ we know that God, while he is fiercely projected upon, is far more than mere projection. Christ is God in Concrete. Christ confirms the Judaic understanding, inherited by Christianity, that God has placed a need in us (call it obsessional neurosis if you will) so that we might respond to Him under the conditions of existence (The Fall). Our freedom entails this anxiety. Christ has taken the religious experience out of speculation and put it in concrete.

Freud's theory is valid for Christianity insofar as it deals with the *ego* involved; but it fails to take seriously the *theo* involved. His understanding of the ego is most important. His understanding of God in Christ is not at all apparent. His theory is splendid etiology. But it is not the basis for a teleology.

Lurking behind all this is the very real probability that it is the religious person who has let Freud down, rather than the other way around.

[11] *Ibid.*, p. 76.

Freud addresses the religious person of his day: "You have to defend the religious illusion with all your might; if it were discredited . . . then your world would collapse, there would be nothing left for you but despair. . . . From this bondage I am, we are, free. Since we are prepared to renounce a good part of our infantile wishes, we can bear it if some of our expectations prove to be illusions."[12]

What spokesman for God, with so great a message, can afford to be put on the defensive with the advance of science and its concommitant moral decisions? The freedom to renounce our infantile wishes is prerequisite for maturity in religion as in any other part of life. Only God is not a part among others. He is He whose demands give our life its wholeness.

The book is an important one. It is especially important in a theological curriculum. We need to know that many people have thought, and still do think, as Freud thought. We need to understand why. Because the presumed conflict between science and religion is not altogether past from the grass-roots of our religious life, Freud's essay has both historical and contemporary importance.

The reader who is acquainted with psychoanalytic theory will be prepared for what Freud says. He will find a fresh clarification of a number of issues. Perhaps most valuable is the chastening experience of being driven with Freud to look to culture for the ultimate answer to man's life. That has always been a temptation for the believer as well as for the agnostic. And if the believer by the grace of God is wary of it, he can thank Freud for a radical insight into what it is in man that enables him to receive that grace.

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Introduction to a Clinical Ministry

The Soul sees itself through itself.—
St. Augustine

It is a tragedy that the good news (gospel) that is so alive and meaningful in one age should harden and become the fixed and lifeless dogma of another generation. It is tragic that ministers, who were psychotherapists even in prehistorical times, should repeatedly lose the ground of individuals and fail to be able to minister meaningfully to many of their parishioners. As a chaplain and a psychologist in a state mental hospital, we have become concerned with aiding the minister in carrying out his most ancient task.

We have become sort of soil specialists, having had to learn what will grow in the ground of an individual. We sometimes must deal with

[12] *Ibid.*, p. 95.

the most barren of all soils and at other times with soils so rich that life grows in choking, chaotic profusion in them. When confronted with an individual in distress the most valuable single thing the minister could know is what is potential in this person. What could develop in him? What could he become? What is natural to him (in a sense larger than the simply carnal)? What is the aim of being in this person?[1] Along a particular line he can develop, oftentimes easily. Along other lines, however right, he cannot grow. Traditionally, ministers have been educated to concern themselves with the pathological in persons who have come to them in distress. In a religious sense this means seeing the individual as having fallen from faith. Or, when the minister borrows from psychiatry and psychology, he takes over the pathology-oriented views of these professions. In both ways the minister is shut off from a more positive approach to the persons in distress.

What we would demand of the minister is that he take a positive view of man from his own frame of reference. Without diagnosing, without judging, without becoming wholly concerned with drives, we would urge the minister to use the insights of psychiatry in a way appropriate and necessary to the minister. Let him be concerned not with what is in the distressed person's unconscious, but with what is the blocked aim of his soul or being. It is in this clinical ministry that most ministers are lacking. Clinical examples will clarify what is meant.

If a person trembles with anxiety, the tendency of the medical practitioners is to diagnose (psychoneurotic reaction, anxiety type) and treat the symptoms with one of a hundred of the popular new drugs. The drugs tend to kill the anxiety or stifle its expression. The patient looks a bit better, but the cause of his difficulty is untouched. The prevailing medical view (certainly not true of all physicians) is that anxiety is a bad thing and should be removed. A minister with a positive view of the individual can see the same person in a far different light. A person is anxious—perhaps it is a woman. What in her is seeking expression? What in her wishes to be done? Perhaps, on careful inquiry, one finds that she is trying to keep out of her awareness the feeling that she is trapped with a husband in a family situation she can't bear. The anxiety turns into sad reflectiveness. Something in her wanted a more meaningful sort of life than the one she finds herself trapped in. Then the anxiety is a sign that new meaning is attempting to appear. In the human relationship between her and the minister this meaning she seeks can be explored. Gradually this is permitted to find expression. Even with a husband she doesn't like she can rediscover meaning in her life.

Many physicians would have stifled the anxiety as a pathological symptom. Many ministers would have cajoled her with dogma and made her feel more guilty for not being able to hold to faith in her time of stress. The psychotherapist (be he psychiatrist, analyst, or psychologist) is not so crude as this. With his frame of reference he tends to uncover the lie behind the pathology. He soon finds she is unhappy with her husband. Then the anxiety takes on the meaning that she wishes to leave him and

[1]To those who wish to pursue the matter more deeply our general orientation is reflected in the work of Paul Tillich.

find satisfaction elsewhere. She is ambivalent and anxious because she wishes to break her own moral code. Is this drive anxiety, that is, anxiety due to sexual drives breaking into awareness? All this is partly true, but such a view overlooks the larger meanings and satisfactions she wishes to establish in her life. The tendency is for the medical therapist to overlook religion, the wish for a family unit, and a desire for meaningfulness in her life as somewhat of a rationalization, a dodging of the key issues of sex, aggression, the lie behind the pathology, whereas we would center in the truth which is disrupting her life by its bold entry. Further examples will help clarify this viewpoint.

A man in his late twenties came for counseling because he believed that he was homosexual. Jim complained about feeling depressed and that somehow he just wasn't normal. He had concluded that he was homosexual because he was experiencing difficulties in establishing adequate relationships with women. On several occasions he had become interested in girls, but, as soon as he sensed that a girl was becoming interested in him, he would find reasons why she would not make an adequate wife and he would back out of the relationship. At first he could not understand why his therapist was not interested in finding out what was wrong with him. Homosexuality was certainly something bad. The concern of the therapist was to discover what was trying to emerge in this person's experience. The counselee was a college graduate and was doing quite well in his chosen profession. As the counseling relationship continued, it became evident that Jim was searching for more meaningful interpersonal relations in general, not only with the opposite sex. It became apparent, too, that a sensitivity to color, sound, and emotion was attempting to emerge and it was this that frightened him and led him to conclude he was homosexual. Because the therapist did not focus on the pathological in Jim's experience he seemed relieved and more able to accept himself. About the seventh session he had this to say: ". . . for the first time in ages I don't feel the weight on my chest, the pressure of my job and living. Just feel emotionally relaxed, not even Dvorak's New World Symphony can depress me. I actually feel *normal.* I feel like a normal human being. I feel like calling my friends and telling them that I just decided I *am feeling great.*"

This is a brief resume of a relationship which covered several months. To have been concerned with homosexuality would have served a limited function and may have created additional anxieties by highlighting the stigma of homosexuality. As therapy progressed, new and creative aspects of Jim's life were discovered. As these aims of the soul, aims of being, became acceptable to him significant changes began to take place in his attitudes and behavior. Two years later the therapist received a wedding invitation from Jim and a letter saying that he had "found himself" and that he felt quite confident about the future.

Mrs. X was 35 years of age at the time of her admission to a mental hospital. She was married and the mother of one child, a daughter in her early teens. The admitting complaint was that of acute depression with suicidal tendencies. She spent most of her time in her room crying and, when not doing that, she shuffled around the unit with a sort of "hang-dog" expression on her face, her shoulders stooped and her eyes red.

The first treatment she received was massive doses of drugs. After some months these were discontinued and electric shock was administered with some results. She was then sent home on leave of absence but returned in a few days because she was depressed again. At this point she was put in the care of the chaplain.

Mrs. X came from a Christian home, was converted at an early age, and upon graduation from high school attended a Bible School. While at Bible School she felt called to the mission field but before this call materialized she met a man fifteen years her senior, became engaged to him and shortly after became pregnant, necessitating marriage. Because the husband was not interested in church Mrs. X did not attend church for a period of ten years. Five years prior to hospitalization she had gone back to her church, taking her daughter with her. She became a Sunday School teacher, the sponsor of the high-school youth group, and the president of one of the women's groups. She exhibited a considerable knowledge of the Bible, was a firm believer in the efficacy of prayer, and was quite well versed in the doctrines of her particular church. She professed a deep love for God, for her family, and for her church.

In the early stages of her therapy, Mrs. X was somewhat annoyed when her therapist did not seem to be concerned about her depression or her elaborate schemes for suicide. She kept complaining about her depression and wished that God or someone or something would take this from her. Gradually she found it possible to talk about herself, her marriage, her feelings toward her daughter, the meaning of her Christian faith. She began to see where her life had bogged down and what steps she would need to take to enable her to become a better Christian. This wasn't easy. She had to struggle.

This brief account of the case of Mrs. X does not seek to prove anything but rather to illustrate a point of view, namely, that the observable behavior of persons in distress is most creatively understood when approached positively rather than pathologically. The depression of Mrs. X was not something to be doused with drugs or forgotten through electro-shock treatment. Both were tried without success in the early stages of her treatment. Her deep sense of guilt and depression were nature's way of saying that constructive aims were blocked. To have bogged down with the pathological aspects of her depression and guilt and their treatment would have missed the point. It appears that we are destined to be adequate, that there are aims within us which seek fulfillment. When these aims are blocked, life begins to send up distress signals. An adequate reading of the signals can lead us to the heart of our problem. For Mrs. X they led to those areas in her life where her growth had failed to materialize.

To concern oneself with the aims of being is fraught with a number of problems. The minister will need to accept the idea that the aims of being cannot be prescribed. To assume that one knows the direction another's life must take is hopelessly to block growth. This is a trap many ministers fall into, for the average minister is trained to tell people how to live and not to provide the conditions under which, as Carrier has put

it, persons are "free to grow." Another difficulty must be faced; a minister may feel anxious that, if he really explores what is natural to a particular person, this may lead the person away from the faith. On a deeper level this anxiety reflects a lack of faith on the part of the minister. Yet, if he knows the way to the palpable God, he need have no fear. If he doesn't know the way (which is what this anxiety expresses), then he has much to fear.

For the great majority of persons that come to the minister for help, what he does will be limited only by his insight into—and ability to grapple with—the spirit in himself and the other person. In a clinical ministry there is no fixed Word. The word is being written here and now in this person before you.

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Necessity and Freedom in a Concrete Case

Out of the experience of the minister confronting desperate stress comes both the practical and theoretical problems of man's freedom.

Take the situation of a fourteen-year-old girl. She is falling behind in her school work. The parents exert great pressure on her to keep up. It is important she be able to go to college, they say in their actions, for a college degree is a status symbol of success. Any suggestion by the school that perhaps the girl is retarded is vehemently rejected. Any problem she might have is the result of the school's mishandling.

As one examines the girl's circumstances more carefully, he discovers several factors. Some simple tests by a psychologist suggest that she is anxious, depressed, extremely hostile, and possibly schizophrenic since infancy. On top of a probable brain injury has been built a superstructure of anxiety. The anxiety has grown out of a very demanding, domineering mother and a very rigid and anxious father. Through the years the girl has been unable openly to resist the parental domination for fear of a total rejection. While her potential capacity is restricted, it is restricted even more as a way of expressing hostility to the parental pressure.

The question now arises: What freedom does this girl have to make choices—choices regarding her functioning in school, choices regarding her attitude toward her parents, choices regarding her way of relating to others? In the "giveness" of her situation there is the biological organic limitation. There is the psychological functional limitation. There is the constant factor of an anxiety-filled milieu. She presents a picture of determinism so great that the very idea of freedom of response seems out of the question. She expects rejection in every relationship and so reacts *in advance* with hostility.

Much of the discussion of freedom is relatively worthless because it sets up a wrong framework. We speak of "free will" as though response to any given situation takes place in a vacuum: there is no previous

pattern of relatedness, there is a neutrality of values, there is nothing but the completely free-floating individual and an isolated situation. In contrast to "free will" we put the category of "determinism," as though response to any given situation takes place in an inevitable fashion, as a train going down a track; there is a previous pattern of relatedness, the question of goals is of no consequence, there is only the already established reaction. Both terms distort what is. Free will gives us a picture of an isolated disembodied spirit. Determinism gives us a picture of a mechanical object. The free-will theorist would conclude the girl can do anything she wants. The determinism theorist would conclude she can do nothing.

Now, then, nobody lives in a vacuum. We are always born into any already existing situation. As a part of the "giveness" of the girl's situation is the biological inheritance, the brain injury (probably resulting from carelessness in the delivery), the parental constellation of anxiety, the girl's own potentiality for responding—these are the necessary factors she deals with from the beginning. These are the "givens." Set over against that the fluid situation of new factors converging on the situation. The girl's response to her parents, her parents' response to her, the encounter with friends, playmates, teachers, ministers, counselor. Something happens to her, but unlike a "Tabula Rasa" (a blank tablet), she in turn responds to it.

To act on the assumption that behavior is meaningful is not the same as saying it is as mechanically and rigidly determined as a train's going down a track. In her we see how her responsiveness is restricted because of unhealthy conditioning from the very beginning. Yet it is still response and not merely mechanical reaction. However, her area of freedom is considerably narrowed. She is unable to rise above her response—reaction pattern—to see what is going on, to weigh what is important and what is unimportant, to make a choice.

The introduction of new factors alters the already existing patterns. Her relation with a teacher can perpetuate and reinforce defensive withdrawal and hostile resistance. At the same time, a more accepting, less demanding relationship can begin to disrupt her picture of the world. She will not know how to react to this "strange" behavior. Her previous knowledge of expectation will not help. In desperation she will make demands, so as to get the person to fit into the understood pattern of pressured rejection. For only then can she continue her hostile withdrawal pattern. Over a long period of time—because the initial "giveness" is so restricting—and after frantic testing to break the accepting pattern, she will begin to change her view of the world. Not all adults are rejecting. Not all relationships produce unreasonable demands. There emerge tentative gestures of response. She chooses to be less withdrawn and a little more open. Her area of response is slightly widened. She comes to feel—probably more than understand—that some adults will not hurt her and so she can go out to them, while other adults will hurt her and so she can withdraw from them. No longer is there pre-established and inevitable hostility. There is a slight differentiation of her environmental situation and a slight differentiation in her response.

Freedom is a combination of the "giveness" of a situation and the integration of all factors in making a response. Freedom is qualitatively

different from the "spontaneity" in subhuman life as expressed in Heisenberg's law of probability or indeterminacy. While the responsive freedom of man is different in kind and not degree from the reaction probability of matter, among human beings themselves freedom is different in degree. There can be greater freedom and lesser freedom. This girl's ability to respond to her total environment is less than that of the person whose biological inheritance is more adequate, whose organic constitution is more perfect, whose parental constellation is less anxious. This individual's ability to respond is greater. His area of freedom is broader. But the difference is in degree, not in kind.

This understanding of freedom—or, to use another term, "responsibility"—is essential. The expectation we find in each situation is unique. We should not anticipate the same response on the part of every person. The minister can so easily blame himself for failure, when in actuality he expects more response than is possible. Expectation of what can take place with the girl is limited. We should not anticipate her becoming an "A" student. She does not have the capacity. We should not expect her to be able openly to oppose her parents and to make her own decisions. The restrictive atmosphere is too great. In these circumstances there can be only very limited goals. For example, at the beginning of her relationship with a minister, she identified with animals almost completely. Her real world was projected on to the lives of animals. An injury to a bird was an injury to her. A fight between dogs became the arena and combatants of her inner turmoil. In this instance a legitimate expectation would be helping her to live less in fantasy and closer to reality. A real advance in her freedom came when she could detach herself from the defeat of a favorite horse in a race and see it as a defeat for the horse, but not a defeat for her personally. Only as the minister sees the limitations of a person's freedom and responsibilty will he distinguish between realistic and unrealistic expectations.

Freedom is always qualified by what we find within the "giveness" of each person's background. Freedom is always potentially greater as a person is given the modifying experience of acceptance in spite of behavior, and of respect for his capacity to decide to act or not to act as he sees fit.

JAMES B. ASHBROOK

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Ministerial Drop-Outs: A Note

A relationship between ministerial drop-outs and clinical pastoral education has been noted by Chaplain Supervisors and theological educators alike. The relationship may be causal or it may be purely coincidental. A statistical comparison of ministerial drop-outs from a clinical training center during the decade 1945-1955 and from several seminaries during the quarter century, 1900-1925, prior to the inception of clinical training throws additional light on the question.

Bruder and Barb found that 10 per cent of the alumni of Saint Elizabeths Hospital (13 out of 122 respondents) left the ministry. They state, "National figures on the number of students who leave the ministry

after entering seminary are not available, but it is believed that they are considerably higher."[1]

William Adams Brown, in *The Education of American Ministers,* reported a survey of ministerial drop-outs in a sample of 6,000 alumni from 11 leading seminaries between the years 1900-1925. The survey found that 10 per cent had left the ministry for secular vocations soon after graduation from seminary. By 1925, 20 per cent had entered secular vocations. The two studies produced identical findings insofar as the number of initial drop-outs is concerned.[2]

From a statistical point of view clinical pastoral education is not a significant factor in ministerial drop-outs. The comparison of these two studies suggests that a constant number of ministerial candidates drop out of the ministry after completion of seminary studies whether they enter clinical training or not. Bruder and Barb report that, of those who dropped out, only 1.5 per cent said that clinical training was a deciding factor in their decision. A statistical study of drop-outs among recent alumni who have not participated in clinical training is needed to confirm this proposition.

Statistical study takes no account of the role of clinical pastoral education in clarifying for the student his motives for dropping out of the ministry or his goals in subsequent employment. It speaks only to the issue of the responsibility of clinical pastoral education for a student's change of vocation. It lends weight to the opinion that the relationship between clinical pastoral education and ministerial drop-out is coincidental rather than causal.

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[1]Bruder, Ernest E., and Marian L. Barb, "A Survey of Ten Years of Clinical Pastoral Training at Saint Elizabeths Hospital," Mimeographed, June 1956, p. 31. (A report of this study also appeared in this *Journal,* 1956, Vol. 10, 86-94.)
[2]Brown, William Adams: *The Education of American Ministers,* Vol. I, Ministerial Education in America; New York, Institute of Social and Religious Research, 1934, pp. 51-52.

BOOK REVIEWS AND NOTICES

Edited by The Rev. Rollin J. Fairbanks

American Handbook of Psychiatry: Edited by Silvano Arieti; Basic Books, New York, 1959. 2098 pp. $25.00

These two volumes by one hundred and fifteen major figures in American psychiatry represent a most welcome "compendium of developments, concepts, trends, techniques, methods, advances, problems and prospects, in which every leading school of thought and every major approach are represented." The choice of contributors, the majority of whom are dynamically oriented, as well as the vast range of subject matter covered, makes good this rather wide-reaching claim.

To list even part of such a vast array of material in a review for this *Journal* would not accomplish our purpose. The whole range and basic concerns of present-day psychiatric thought are most helpfully covered so that the layman can gain a solid grasp of a complex and most confusing approach to human problems. That it will not go deep enough for the specialist is obvious; but there is sufficient evidence from what is presented, and the way in which it is presented (with abundant references), that there should be a decided stimulus to further study.

For the clergyman there are many papers of significant import. These are mostly to be found in Volume II. The three chapters on the psychotherapies (fifteen papers); one chapter on "Contributions from Related Fields" (eleven papers, six dealing specifically with religion); one on "The Management and Care of the Patient" (four papers); and the final chapter, "Legal, Administrative, Didactive and Preventive Psychiatry" (six papers), are well worth the price of the two volumes.

That so much space and attention has been given to religion, Eastern as well as Western, would appear to indicate that psychiatry is beginning to make gestures in the direction of an exploration of what these two major disciplines dealing with human living need to know about each other. This should be taken as a heartening sign for future collaborative investigation of the theories, doctrines, techniques and practices by which each of the two disciplines seeks to be of help to people in their living. The six contributors here have aided materially in effecting such a joint venture.

Without question these volumes will prove to be a decided asset to the chaplain supervisors' clinical pastoral training library. Not only do they make readily available an up-to-date body of dynamically oriented material, but they do so in a stimulating and challenging manner. The serious teacher and student alike will find much both to induce further research as well as to encourage even greater interdisciplinary conversation and teaching.

This reviewer has only one major criticism. Such a wealth of material should never be bound within the covers of only two volumes. It is exhausting enough to grapple with the strong subject matter without

having to expend considerable energy supporting such heavy-weight volumes. It would have been more desirable to have material in five volumes, which would make the mechanical process of reading much easier.

ERNEST E. BRUDER

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The Art of Loving: Erich Fromm; Harper, New York, 1956, 133 pp. $3.00.

As is characteristic of Erich Fromm's books for the most part, *The Art of Loving* is a summary of much of the essence of previous books and an advancement into new fields of investigation. In most respects it is an excellent book, and perhaps it is the best objective analysis of love and its significance in the contemporary Western world which could be made.

The author's context and purpose are indicated in the book's Foreword, where he states: "This book . . . wants to show that love is not a sentiment which can be easily indulged in by anyone, regardless of the level of maturity reached by him. It wants to convince the reader that all his attempts for love are bound to fail, unless he tries most actively to develop his total personality, so as to achieve a productive orientation; that satisfaction in individual love cannot be attained without the capacity to love one's neighbor, without true humility, courage, faith and discipline."

The Art of Loving is divided into four parts. In the first part, Fromm asks the question, "Is love an art?" and then examines the possible reasons for the peculiar attitudes toward love prevalent in modern Western society. He then answers his own question in the affirmative, and states three steps which are necessary for the mastery of any art; namely, the mastery of theory, the mastery of practice, and an interest in the particular art to the degree of ultimate concern.

In the second part of the book, the author turns to the theory of love. He states that "separateness" is the major problem of human existence. The term "separateness" here is used to cover and include everything previously, in *The Sane Society,* included under the term "alienation" but in a more general and less technical sense. Then, after an exposition on three partial solutions to man's problem of separateness, he states that the ideal solution is love properly conceived. Following this, there is a somewhat extended explanation of the love relationships between child and parent, and between the "I" and various love objects.

In a third section entitled "Love—Disintegration in the Western World," Fromm links our theories and practices of love up with our economic and social patterns with particular emphasis on the former. He is particularly critical of the modern "teamwork" type of marriage which aims at continually ironing out all of the wrinkles which appear in the love relationship without ever arriving at a "central relationship." The primary aim seems to be to "treat each other with courtesy and . . . attempt to make each other feel better." Following this he advances a logical critique of Freud's primarily sexual orientation, and of various types of "pseudo-love" (e.g., idolatrous love, sentimental love). This section is concluded by a criticism of religion and love (as the author criticized psychiatry in *The Sane Society*) for being primarily "happiness" orientated and/or success orientated.

In the final section, there are several suggestions for the cultivation of love, and it closes with a delineation of love as primarily a "faith" relationship.

This reviewer finds Fromm's whole approach to be too rational, logical, and cut-and-dried. In fact, it is so much so that there is an air of unreality about much that is said. In the section on love toward God one gains some idea of Fromm's personal position and of the basic unreality of the subject which he is discussing. It is as if, while never knowing God in any real sense, the author, in addition, had never really known love either. This is, of course, not the only explanation for an apparent sterility of the author's treatment. There can be little doubt after reading *The Art of Loving* of Fromm's justified hostility toward the sentimentalistic view of life as it much too frequently manifests itself in our culture. Perhaps Fromm has over-reacted in these terms.

Furthermore, on the basis of a considerable reading in problems of mental health, this reviewer questions whether it is possible to teach, cultivate or instill any extensive and genuine sense of love in a person who has or had not experienced it by the following of a set of logical rational principles. If a person is to be "converted" to love, the conversion would have to be accomplished on the emotional level.

In fact the whole problem with Fromm's approach, the rational emphasis noted in different contexts in the above two paragraphs, is also one of the points on which the author criticizes Freud's approach. While there is a large measure of truth in some aspects of this criticism (e.g., in terms of Freud's overemphasis of the sexual aspect of love), it would nevertheless agree with Fromm's premise that love is "a rational phenomenon . . . the crowning achievement of maturity." For this reviewer such a concept of love as a purely rational phenomenon is unreal. A better criticism of Freudian sexual primacy comes from Viktor Frankl, the existentialist logotherapist, who claims that Freud is more out of date than wrong, a judgment which Fromm implies in this book and states more extensively in *The Sane Society.*

Despite the broadness of the above criticisms, *The Art of Loving* is a very important book and contains many extremely valuable insights, especially in terms of the faults and weaknesses of modern Western culture. Certainly no clergyman should fail to read it.

LAWRENCE C. FERGUSON

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Jewish Medical Ethics: Immanuel Jakobovits; Philosophical Library, New York, 1959. 381 pp. $6.00.

The literature of medical ethics has been heavily dominated by the contributions of Catholic moralists. For this reason, if for no other, the appearance of the first comprehensive treatise on the subject of Jewish medical ethics is significant. The author, an authority on medicine and Jewish law, uses an historical approach to trace the development of religious views of medico-moral problems from antiquity to the present day. He does not confine himself entirely to Jewish law, but frequently alludes to and summarizes Catholic and Protestant opinions in comparison.

In addition to discussions of the usual topics involved in this field such as contraception, sterilization, abortion, euthanasia, and post mortem examination, the author devotes several chapters to the physician in Jewish religious law, his studies and privileges, his professional charges and his responsibilities.

Approximately one-third of the book is devoted to documentation, with the notes and references being given at the end of the book. There is an exhaustive bibliography of ancient and modern Jewish medical writings and a good general bibliography on medical ethics, but no index. The readability of this book, of course, does not compare with the lively discussions of the Protestant position by Fletcher and Sperry, but this is chiefly due to the nature of the legal material which the author must compile for his purpose.

The author acknowledges that his material is mainly historical and cannot be used as practical directives either by patients, doctors, or chaplains apart from an examination of the facts in each individual case. As a reference work, however, it will make a worthy addition to nursing school and medical school libraries and can be read with profit by all who seek to understand the contribution which religion can make as a guide to moral conduct in an often perplexing scientific age.

ALBERT L. MEIBURG

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Collected Papers: Sigmund Freud; (Five Volumes, Boxed) Basic Books, 1959. $25.00.

These five volumes represent Volumes 7 to 10 and No. 37 of the International Psychoanalytical Library under the editorship of the late Ernest Jones. The translators, Joan Riviere and the Stracheys, are noted for the clarity with which they have made Freud's writings available in the English language.

In Volume One we have some of Freud's earliest papers dealing with his clinical work: for example, "Sexuality in the Aetiology of the Neuroses" (1898); "On Psychotherapy" (1904); "Freud's Psychoanalytic Method" (1904); and particularly a very fascinating and quite lengthy section where Freud describes the history of the psychoanalytic movement (1914).

Volume Two continues the "clinical papers" (it should be mentioned that the first four volumes contain a selection of the major writings in the order in which they were published); and Volume Three gives all the data on the five major cases on which Freud was clinically able to establish his postulates: The Case of Dora; Little Hans; A Case of Obsessional Neurosis; The Schreber Case; and The History of an Infantile Neurosis.

Volume Four contains papers on Metapsychology and Applied Psychoanalysis, among which of specific interest are "Mourning and Melancholia" (1917); "The Taboo of Virginity" (1918); "The Moses of Michaelangelo" (1914); and "A Neurosis of Demoniacal Possession in the Seventeenth Century" (1917).

Volume Five offers selections from Freud's "Miscellaneous Papers" between 1888 and 1938, among which, of special interest to clergymen concerned about depth psychology, are: "Psychoanalysis and Religious

Origins" (1919); "Remarks Upon the Theory and Practice of Dream Interpretation" (1923); "Postscript to a Discussion on Lay Analysis" (1927); "A Religious Experience" (1928); and the famous "Analysis Terminable and Interminable" (1937).

To read his own writings is to find Freud a careful, patient, persistent and almost possessed investigator of the phenomena that take place in us as human beings. He was not to be swayed by prejudice, opposition or even militant shame (his own or that of others) from investigating what actually went on in the hidden recesses of the human mind, and from asking the questions, or entering the areas of human concern which had constantly been tabooed by society. In a day when so much of what his pioneering work has achieved is simply taken for granted, it is a moving experience to read first-hand what happened and what he thought as the great investigator of the unconscious made available to others his "incredible findings."

Publication of *The Collected Papers* is a valuable asset to the serious student interested in the development of "the psychoanalytic movement." Especially is such material needed in a time when there is so much concern about "what Freud said" and with so few really knowing what that brilliant clinician did claim. However, it is doubtful that this publication will have more than passing interest to the busy pastor, even though he would gain much from the careful reading of these brilliant papers. But for the Chaplain Supervisor, interested in assisting his students to obtain primary source-material for their understandings of dynamic psychiatry, the *Collected Papers* are an invaluable and necessary addition to his clinical pastoral training library. ERNEST E. BRUDER

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Clues to Suicide: Edwin S. Shneidman and Norman L. Faberow; McGraw-Hill, New York, 1957. 227 pp. $5.50.

Written by two psychologists (in association with medical, social work, sociological and legal specialists), this volume consists of a collection of short papers which outline some of the contemporary thinking in regard to the little-understood problem of suicide.

The opening chapter (by the authors) presents some very interesting observations on the notes which are left behind by those who have taken their own lives. While considerable literature exists on this subject of self-destruction (nearly 500 publications in English and over 1200 in foreign languages, in medical literature alone), this is the first book of its kind that has come to the attention of this reviewer. In a sense it is a handbook that offers an excellent introduction to the subject for anyone who is interested and willing to accept the responsibility which such knowledge provides. Dr. A. E. Bennett (in Chapter 18) estimates suicide deaths in this country to be 50,000 per year. In the judgment of this reviewer such a figure is much too conservative, a more realistic estimate would bring the total nearer 150,000! The problem of the suicidal patient is such a serious one that reading and re-reading this little book should be considered as minimum basic exposure to the subject. Additional insight can be gained by exploring the bibliography which Karl Menninger includes in his *Man Against Himself.* VIGGO W. JENSEN, M.D.

Self Destruction: Beulah C. Bosselman; Charles C. Thomas, Springfield, Illinois, 1958.

This excellent book points out some of the dynamics of suicide and attempts at suicide. The reader without technical knowledge of psychology realizes, perhaps for the first time, that a move toward suicide is typically the culmination of many broken lines of relationship in the person's life. This event in itself is not an isolated one—one that can be seen easily as having been "caused" by a specific event just prior to the overt act. It is shocking that the will to discontinue life can be traced to the infant state—shocking, because even at that stage in life the human mechanism can sense, apparently, the rejection by other human beings resulting in a loveless and meaningless life.

It is also interesting that many "successful" suicides are recognized by psychiatry as the result of miscalculation. Rather than self-destruction, such moves actually are designed to hurt and/or humiliate others rather than the self. But errors of judgment occur which result in death.

The analysis of the dynamics of suicidal gestures by young adults is significant because of the implications of modern life, especially for a clergyman: "The young adult may translate . . . thoughts (of death) into a self-damaging act which symbolizes the violence but does not express a real determination to die." In pastoral counseling, a minister would be aided by recognizing such manifestations of wishes. Such knowledge is helpful in determining whether referral to psychiatric help is to be made.

Like so many other tragedies of human life (e.g., pregnancy out of marriage), suicide frequently involves action directed against some close person rather than being in itself a "sinful," isolated act. The understanding of this dimension of human life is helpful for the clergyman if he is to minister adequately to people and if he is to help in preventing such tragedy.

ROGER C. MOULTON

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The American Funeral: A Study in Guilt, Extravagance and Sublimity: Leroy Bowman; Public Affairs Press, Washington, D.C., 1959. 181 pp. $4.50.

This book is an excellent survey and a moving commentary on America. Thematically the author opposes the rank materialism of the American funeral. But his effort is not polemic. He offers much understanding and insight into funeral practices, custom and business.

The author reviews many things of interest to the clergyman, the social worker, the funeral director and especially to the average person. Dr. Bowman understands the need for the expression of grief, but he examines the situations in which it can be manipulated in the interest of financial gains. He also appreciates and discusses at length the very real need of the business man—mortician for status and economic security.

Throughout the book the basic grief situation produced by death is viewed as one where material display is inappropriate for the expression

of true feelings. At the time of death the author sees the need to focus on life values, and the parallel need for counseling by trained persons and for support by friends and relatives. He finds the social role of the undertaker to be ill-defined and believes that many abuses arise from this fuzzy definition of the proper business role of a needed servant of the public. The often explicit and always implicit counsel of the undertaker as to how meanings and values shall be expressed at the time of death are found to be the least satisfactory assumption of a role by the undertaker.

The chief value of this book and the thread that continually lights its pages is the emphasis on human values in the funeral situation. The concluding chapter on "Meanings and Meaningful Funerals" analyzes the basic concerns of the bereaved person. Here are suggested the values which a funeral ought to represent. In the several appendices cremation, reactions of children to death, plans to give eyes to restore sight and bodies for medical research are also considered.

PAUL E. KILLINGER

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The Church's Ministry of Healing: A. H. Purcell Fox; Longmans, New York, 1959. 115 pp. $3.00.

Written by an English hospital chaplain, this book is pleasantly free from theological jargon and is marked by a wise restraint. The author sets forth competently and concisely the ministry to the sick as it is provided within the Anglican Church. He explains what the clergyman may do and why he does it, and he also stresses how the laity can and should share in this ministry of the Church. It is a responsible and reliable presentation, and its limitation is an understandable one, namely that its frame of reference is one particular Christian communion.

ROLLIN J. FAIRBANKS

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Bigger Than Little Rock: Robert B. Brown, Seabury Press, Greenwich, Conn., 1958. 150 pp. $3.50.

The name, Little Rock, is socially, culturally, and morally embarrassing to many citizens. In that moderate city "irrational man" broke through in America and that "break-through" understandably has been disturbing.

The Episcopal Bishop of the Diocese of Arkansas, who had to wrestle with the prophetic and pastoral role of the Church in an emotionally loaded situation, has written a forthright and reflective book on the complex issue of school integration. He highlights the lack of programming and education for mandatory social change which led to a breakdown in communication between diverse groups: white and Negro; intellectuals and non-educated; politicians and citizenry; white and white; and Negro and Negro.

By and large Bishop Brown, while tracing the events which led to mob action and military intervention on the side of the law, has written a general confession. He shows that, throughout the continuing affair, the Church (through both denominational and interdenominational action) upheld the Pauline dictum that, under God, there is neither "bond nor

free, Jew or Gentile." Under the stress of strong emotional drives, however, few were willing or able to listen. The author arrives at no easy solutions or practical programs, save to recognize that the law, as set forth and interpreted by the Supreme Court, is socially and morally valid and, therefore, must be upheld. Thus, the heart of the Gospel, the Ministry of Reconciliation, is seen to be the primary role of the Church in the situation, so that men might truly meet their God and communicate with and understand their fellow man.

It is to be regretted that the Bishop seems to equate the prosegregation Citizens' Councils with the integrationist N.A.A.C.P. in the picture. The views of each group are, of course, "extremist" on the issue, but the moral justification of the latter would seem to divide them as sharply as Dives and Lazarus. However, to a thoughtful, moderate man caught in the midst of the turmoil, it is easy to see how the intensity of feeling of the respective parties might make them seem to be in the same camp, ignoring social realities.

WILLIAM B. SPOFFORD, JR.

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The Larger Parish and Group Ministry: Marvin T. Judy; Abingdon Press, New York, 1959. 176 pp. $3.00.

Heavily sociological in emphasis, this book deals with methods and techniques for consolidating denominational or interdenominational church activity in our nation's town-country and rural areas. Since the author does not devote a significant share of his work to evaluating what social and ecclesiastical losses often attend such consolidation, the book is much less helpful than it could be. Also, of necessity, the population and social mobility statistics are based on the 1950 census and, thus, we are presented social facts which, for the most part, are a decade behind the times. The discussion of the methodology for establishing a larger parish and a group ministry is accurate but not very deep, chiefly because the author does not deal with the psychological dynamics of understanding and motivating people operating on the basis of tradition and social inertia.

WILLIAM B. SPOFFORD, JR.

OUR REVIEWERS

Ernest E. Bruder is Director of Protestant Chaplain Activities at Saint Elizabeths Hospital, Washington, D. C. . . . *Lawrence C. Ferguson* is Minister-in-Charge of St. Matthews and St. Albans Churches in Redmond, Oregon . . . *Albert L. Meiburg* is Associate Director of the Department of Pastoral Care at North Carolina Baptist Hospital . . . *Viggo W. Jensen* is Clinical Director of the Department of Psychiatry at Detroit Receiving Hospital, Detroit, Michigan . . . *Roger C. Moulton* is Curate at St. Paul's Church, Rochester, New York . . . *Paul E. Killinger* is a clergyman in the Unitarian Fellowship, Bloomington, Indiana . . . *Rollin J. Fairbanks* is Professor of Pastoral Theology at the Episcopal Theological School, Cambridge, Massachusetts . . . *William B. Spofford, Jr.,* is Protestant Chaplain at Massachusetts General Hospital, Boston, Massachusetts.

CURRENT PERIODICAL LITERATURE

EDITED BY THE REV. JOSEPH FLETCHER

"Relationship between Self-Reports and Adolescent Religiosity," by Orlo Strunk, Jr., in *Psychological Reports,* 1958, 683-686.

Early in this century the psychology of religion had a wide vogue with the work of James, Hall, Leuba, and others. With the rise of Behaviorism the interest waned in most quarters but recently there has been a renewal of interest due to dynamic concepts of behavior and experience. The self-concept has also contributed to this renewed interest in the psychology of religion. Books on the subject are appearing again. A study was made to investigate the relation between persons' concept of self and their religious orientation. One hundred thirty-six high-school students were given forms of a Self-Rating Inventory and a Religiosity Index, with significant results. The self-affirming adolescents tended to score higher on religiosity—with a .32 product-moment correlation. Since these results appear to contradict the older notion that religion goes with self-doubt, further inquiry is indicated.

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"The Cliché: A Phenomenon of Resistance," by Martin H. Stein, M.D., in *Journal of the American Psychoanalytic Association,* VI:2, April, 1958, pp. 263-277.

A recording of Danny Kaye's song, "The Babbitt and the Bromide," shows the essential isolation of cliché users. The hebephrenic uses speech as a means of expression, not of communication, and so does the cliché user. Clichés not only feed self-esteem and hide dangerous thoughts; they give reassurance, as prayers do when ritualized. The stereotyped phrases of the schizophrenic have some of this quality. It may, for example, when serving repression, be used to minimize the seriousness of illness ("I'm sure it's all psychosomatic"). The cliché is most striking for its ego syntonic effect, to the point of smugness. Mr. Podsnap in Dickens' tale reduced life's turmoil to a few simple formulas. But its synthetic function restricts ego development, does not enhance it. It is used also to bar communication, between person and person as well as between the parts of one person's psychic structure. There are also some clichés that have emotional impact; slogans. It is growing common for patients to "defend" themselves with psychoanalytic clichés as depth terms become more widely known.

Abstracts by Mr. Fletcher.

NEWS AND COMMENTS

Announcement has been made by Dr. Winfred Overholser, Superintendent, Saint Elizabeths Hospital, Washington, D. C., of the appointment of two new Howard Chandler Robbins Fellowships in clinical pastoral training. The Rev. Leslie W. Hahn, Chaplain at the Ballarat Mental Hospital, Victoria, Australia, expects to become the first clinically trained mental hospital chaplain in Australia. The other recipient of the fellowship, the Rev. Wesley Crowle of Onoway, Alberta, Canada, has been assisted in obtaining his internship year of training in order to return to the Canadian Church and inaugurate clinical pastoral training which will meet the acceptable standards. It is hoped that further funds may be forthcoming by which both these well-qualified nominees will be able to complete the two-year, full-time program offered for chaplain supervisory training at Saint Elizabeths Hospital.

The Rev. John A. Bone, Scottish minister, Edinburgh, Scotland, at present completing his internship training as a Howard Chandler Robbins Fellow, has been recommended for appointment to the second full year of chaplain supervisory training. The Rev. Leslie E. Werner, Jr., a Methodist minister, has recently completed his internship and has been recommended for appointment as a chaplain resident on government stipend. Both will continue in training for another full year.

Three well-qualified clergymen have been granted a Federal Government stipend in the amount of $2800 for an internship year of clinical pastoral training beginning in September 1960. They are the Rev. Enno K. Lohrmann, Lutheran, Chaplain at Spring Grove State Mental Hospital, Maryland, who has been given leave of absence for this one year for this training; the Rev. Robert M. Murphy, Assistant Professor of Religion, Baptist; and the Rev. Fred Shilling, Associate Pastor of St. Matthews Lutheran Church in York, Pennsylvania.

The Rev. Edward F. Dobihal, Jr., Protestant Chaplain at Saint Elizabeths, has recently been appointed as Director of Protestant Clinical Pastoral Training.

The Religious Counseling Center, 5055 Plainfield, N.E., Grand Rapids, Michigan, will conduct a week's Workshop, August 20-27, at Hobby Crest Resort, Ludington, Michigan. Participating families are in individual counseling and group therapy. Pastoral Director H. Walter Yoder and Staff Counselors, Mrs. Lawrence E. Voss and Mrs. Maurice Fairbrother will lead the week's program.

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The American Institute of Family Relations, Los Angeles, California, will conduct its Thirteenth Annual Summer Workshop on the Techniques of Counseling, August 1-13, under the direction of Paul Popenoe, Sc.D., President.